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JANUARY • FEBRUARY 1958

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Human Relations Programs

Changes in School Health

Parents of the Handicapped

Informal Institutional Groups

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

# children ®

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◀

A Puerto Rican child in New York, a member of one of the many thousands of families who have poured into the city from the Caribbean island since the end of World War II, bringing with them language and cultural differences which have created many problems for them in the community. How to preserve good human relations within communities as the ethic composition changes is suggested by the article on page 3.

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Sociologist Joseph H. Douglass came to the Department of Health, Education, and Welfare in 1954 as consultant on intergroup education in the Office of Education and later became special assistant to the Secretary. A graduate of Fisk and Harvard Universities, he has been dean of the Fayetteville (N. C.) State Teachers College, on the faculty of Howard University, and executive secretary of the Washington Urban League.

Before assuming his present position 6 years ago Arthur Lesser was for 3 years chief of program planning for the Children's Bureau's division of health services and for 8 years medical director for Region III. With a medical degree from Washington University in St. Louis, he trained in pediatrics at Children's Memorial and Municipal Contagious Diseases Hospitals in Chicago and at Mt. Sinai Hospital in New York.

Eleanor Reid's article grew out of her experience at the hospital school where she had been on loan from the Iowa Crippled Children's Services to develop social services. With training from the schools of social work at Columbia University and the State University of Iowa, Mrs. Reid has also worked in foster care programs in New York City and with the American Friends Service Committee in Palestine. She now lives in Pennsylvania.

Dr. Helen Wallace has written widely about research undertaken by New York City's Department of Health when she was director of its crippled children's program. She was with that department for 12 years before turning to public health education, first as director of the department of public health at the New York Medical College and, since the fall of 1956, at the University of Minnesota.

With an interest in developing treatment methods for juvenile delinquents out of sociopsychological research George Grosser has achieved a doctorate at Harvard University and served successively as diagnostician and counselor at the Boston Juvenile Court and the Lyman School and as director of the clinical staff at Youth Service Board Detention Center in Boston. He has been at Queens College since 1953.

Psychologist Muriel Brown came to the Children's Bureau a year ago after 10 years of working on overseas assignments for the Army, the Department of State and the Josiah Macy, Jr., and Ford Foundations. A research specialist in parent and family life education, she has been with the National Council of Parent Education, the University of Tulsa and the U. S. Office of Education.

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*Changes in community make-up and school policies are behind the need for . . .*

# SCHOOL AND COMMUNITY HUMAN-RELATIONS PROGRAMS

JOSEPH H. DOUGLASS, Ph. D.

*Program Coordination Officer, Office of the Secretary, Department of Health, Education, and Welfare*

THE PURPOSE of this analysis is twofold: (1) To identify some of the problems and tensions which arise in communities and school systems as they develop human relations programs, and (2) to suggest some possible methods and approaches by which school administrators, teachers and the public might cope with them. The goal of a human-relations program, as perceived by Boykin, is a "unity of interacting personalities bound together in an organized relationship in which the characteristic mode of social interaction is determined not by racial or ethnic differences, interfaith conflicts, socio-economic disparities and cultural and educational factors, but by respect for individual personality, and the dignity and worth of human beings." [1]

Among the problems which may confront schools and communities in the development of human-relations programs are those arising from:

1. Population growth, change, and mobility;
2. An expanded conception of the role of the school as a community agency;
3. Attitude of ethnic groups growing out of previous majority-minority relationships;
4. Inexperience of staff in planning and implementing a school human-relations program;
5. Lag in community education toward the program;
6. Administration anxieties with reference to the success of the school program under way;
7. Internal and external "pressures" affecting the school-community equilibrium.

### *Community Changes*

Numerous communities and schools recently have undergone an unprecedented population increase as a result of the postwar boom in births. By 1955 the elementary-school population numbered 30.5 million, or an increase of 37 percent above the 1940 total. A continuous increase in school population is likely to confront communities for some time to come.

At the same time the population has surged to the cities. Between 1900 and 1950 the metropolitan areas absorbed 73 percent of the Nation's total growth. As a result, the schools, as Hauser says, have been faced more and more with the necessity of "adaptation of the instructional program to general and specific preparation for urbanism as a way of life." [2]

Recently great changes have taken place in the ethnic and racial makeup of metropolitan communities. The majority of newer city arrivals have not been foreign immigrants as they used to be, but Negroes of low economic status who have moved in from rural communities. By 1950, over 90 percent of the Negroes in the North and West, and 48 percent of those remaining in the South lived in urban areas. In urban communities into which large numbers of Negroes have migrated, the schools have been only one of the agencies faced with problems of accommodation.

These trends in population shifts can be expected to continue. As a consequence, in addition to problems of adequate facilities and staffing, schools and communities are faced with adjustments to problems created by changes in ratios and concentrations of ethnic groups in the population. In many schools where the child population until recently has been predominantly white, the situation is being reversed. This puts a responsibility on the school administration to consider, as Hauser suggests, "whether the instructional program conveys an insightful description and understanding of the human-relations problems which are involved, and adequately prepares students for dealing with them with a minimum of friction and hardships?"[2]

While these shifts in population have been occurring the Nation has also been undergoing other social changes including increases in the average size of family, the proportion of aged in the population, and proportion of women in the labor force. Each of these developments is creating complex human-relations problems which either directly or indirectly affect the role and function of the school.

## *Expanded School Roles*

More and more the schools are expanding their roles to help cope with the varying needs of all the people of all ages in the community. They are, for instance, providing opportunities for continuing educational experiences for adults that will be helpful to them in maintaining health, planning for parenthood, child-rearing, acquiring or improving job skills, and carrying out civic responsibilities. Similarly, schools are beginning to accept a responsibility for safety education, driver training, premarital counseling and other types of adult education protective not only of the individual but of society as a whole. Growing numbers of groups and individuals with special needs are turning to the schools for specialized assistance while the schools are turning to the specialized agencies and specialists in the community for assistance in their educational programs.

In many communities into which Negroes are moving from rural areas, large numbers of white residents are moving outward to suburban fringes. The newer residential suburbs are characterized by a high degree of similarity among the residents, in income levels, social interests, and ethnic identification.

By design or otherwise, Negroes and some other minorities are, with few exceptions, excluded from these new suburbs.

Thus many Negroes are finding residences in city areas which have been vacated by whites. To a large extent these areas surround or are interspersed with older business and commercial sections and are typically "low-income status" in comparison with white residential areas. One main cause of segregation of children in school along ethnic and economic lines is this factor of physical residential separation of the populace on the bases of ethnic identity and high and low status lines. New York City currently is wrestling with this problem by transporting students to schools in neighborhoods other than where they reside.

## *Lack of Communication*

Another major problem growing out of residential separation is its effect in maintaining closed channels of intergroup communication and participation. This tends to encourage psychological isolation, attitudinal withdrawal, ethnocentrism, stereotyping, the development of rumor, and actual or potential intergroup hostility or tension.

The vicious circle of residential separation, lack of communication, lack of interparticipation, and the ascription of lower-class status to minority groups tends not only to enhance group loyalties on the basis of ethnic identity, but also to concentrate the control over community affairs in the majority group. This tends to entrench a caste-like situation, especially in respect to Negroes and whites. From the standpoint of occupations, income levels, prestige, leadership, and authority, many members of the white group are at, or above, the norms which both groups look upon as desirable, and members of the Negro group are largely below.

The result of such separateness is that the minority groups tend not only to be categorically looked down upon by the majority group, but to look down upon themselves as persons and as groups. The facts of being regarded inferior on the one hand and of so regarding themselves on the other, heighten their feelings of insecurity, inferiority, and apathy. At the same time, such attitudes tend to incite their feelings of hostility and resentment toward the majority group, thus stimulating aggressive behavior. The more aggressive the minority group, the more negative is the reaction of the majority group, thus still further crystallizing the ethnic isolation of each group.

### *Attitudinal Problems*

Consider now the school system in which an effort is being made to develop a human-relations program, in compliance with a Supreme Court decision with which a sizable proportion of the community is out of sympathy.

In many areas, as previously pointed out, schools already are grappling with problems of overcrowding, staff shortages, insufficient materials, low salaries and inadequate facilities. A large number of "small" school buildings are located in neighborhoods which are undergoing a transition in the racial identity of the inhabitants. Groups and individuals which previously had been separated and isolated largely on the basis of unequal opportunities are now to be brought together theoretically on an equal basis. In both groups anxieties and fears immediately arise among parents, pupils, administrators, and teachers as a result of the lack of previous contact and experience. These are conditioned by the relationships and attitudes which the groups and individuals have habitually had toward each other.

Seldom is there complete sympathy on the part of all publics in a community for the idea of integration as a school policy. Many persons in the majority group fear that bringing children of diverse groups together will lower the ethical and moral standards of their children and the academic standards of the entire school because of the inferior cultural and educational opportunities in the minority group's background. Some are concerned about the possibility of misecegenation. Other fears grow out of the majority's stereotyped thinking about the minority with reference to disease and standards of cleanliness. There are also fears of physical violence and personal bodily harm growing out of group hostility. These fears, anxieties, and tensions frequently produce a high degree of resentment on both sides.

In the minority groups, the movement toward integration is also approached with fears and misgivings. The major anxieties arise from the prospect of nonacceptance or psychological rejection. Members of the minority group are afraid of being laughed at or "made fun of" by persons who in their previous group isolation were conditioned to feelings of superiority. They fear that if a conflict should arise, they will be judged *ipso facto* as being at fault. Often, the minority students expect less than fair and equal treatment from their teacher.

Sometimes, all these fears are reversed, and the minority person is afraid of being overaccepted to the point of being regarded as something special, in which case he would still feel uncomfortable. Having labored so long under a feeling of inferiority, the student in a minority group is sometimes afraid that he will be unable to keep up scholastically with the students of the majority group, even under optimal conditions. He feels that he must be constantly on his guard to protect himself or to defend his conception of his personal honor or self-esteem. However, if, by chance, he is successful in being accepted as an individual by the students of the majority group, he sometimes suffers a guilty feeling of having been disloyal to his own group.

A successful attack on these problems requires the utmost skill, human understanding and individual dedication on the part of administrators and teachers in replacing feelings of insecurity with those of security and feelings of inadequacy with those of adequacy.

### *Staff Inexperience*

A major difficulty in getting effective human-relations programs under way often lies in the inexperience of instructional and administrative staff in coping with the interpersonal and intergroup problems arising in a heterogeneous school population.

Because of policy or location there are three types of schools today: (1) those undergoing a transition from racial segregation to integration; (2) those in which integration has long been established; (3) and those in which segregation of the races is a continuing fact.

Each of these situations presents its peculiar problems. In the schools and communities where integration has been long established, the adjustments to increasing numbers of minority persons are probably not as difficult as in the schools effecting a new integration policy. In the transitional situation apprehensions, misgivings, anxieties, and fear may be acute unless the process of arriving at the policy decision involved widespread community participation and support. If this has been the case, school and community may work together positively, anticipating success. If this has not been the case, the community may be so divided in attitude that the school finds itself in the middle of opposing forces.

Where segregation of the races is a continuing fact backed up solidly by community attitudes any change will depend on the kind of leadership that is exerted in the interest of human-relations programs.

In the transitional and segregated schools many of the teachers themselves may have unfavorable preconceived notions concerning minority groups. Without previous experience and contact with varied ethnic groups, they may lack understanding of what "others" are like, how they feel or what motivations and values are present. When teachers do not know what the children's lives are like, there is a great danger of their misinterpreting the children's behavior, and, as a consequence, of doing or saying things which create misunderstandings and thus intensify rather than reduce problems.[3]

### *The Pressures*

On the administrator depends to a large extent the degree of morale, the organizational efficiency, and other aspects of the success of the school's program. He is the target for criticism from all sides, yet teachers, pupils, parents, the board of education, and the community at large look to him for leadership and direction. He often finds himself in the middle of cross-pressure of conflicting interests among these groups. And because he is human, he also often has in him a mixture of motives, rational and irrational, self-interested and group-interested, conscious and unconscious. These psychosocial pressures may cause problems in his successful adjustment to and direction of the school's program.

Among causes for fear and anxiety, the administor faces the possibility of loss of status with the groups and individuals who are important to him. He needs great conviction when he has to stand for principles to which the community is largely indifferent or even directly opposed. He may even find that his role places him in an antithetical position to the community power structure, presenting the danger of a break between himself and those to whom he is officially responsible.

The administrator may also fear the future consequences of a particular course of action, such as the wholesale withdrawal by parents of their children from the school because of the decision to hire Negro teachers.[4] However, his problems may be lessened in new channels of community participation and communication are opened up by bringing together representatives of all groups for mutual planning and accomplishment of community goals, including the special talents of those groups not directly involved with school problems, such as representatives of civic organizations, church groups, and health and welfare agencies.

In addition to influences and pressures from the outside, a school organization contains various internal pressures. These are brought to bear on the children, the teachers, and the administrator. The members of each group are subject to a complex of stated and implied expectations which apply between and among these groups. The teachers face problems of personal capabilities, of performance and rewards, of getting on with their colleagues, of maintaining the esteem of the administrators, and of fulfilling responsibilities for instructing the children. The administrator faces problems of policy execution, of delegation of authority, of organization, of leadership and coordination. The children face problems of living up to the teachers' and administrators' goals, responding to group relationships among their peers, and fulfilling parental expectations in a competitive situation.

Externally, the community exerts pressure on the school organization in terms of parental and civic expectations. Parents view the teachers as the professional guides for their children. The community expects the children to be safe, happy, and busily engaged in purposeful activity while absorbing useful knowledge and information.

Apparently an equilibrium grows out of the many forces at work whereby the many needs, motives, objectives, and desires are in some degree realized.

Traditionally, the many expectations of the school have grown out of the values and goals of average white American middle-class children, parents, and teachers. For these, the programs, policies, purposes, and organization have been designed. The minority child, parent, or teacher constitutes a threat to the existing equilibrium. The greater the deviation from the norm presented in language, religion, color, social status, or other attribute, the greater are the problems of adaptation in school-community relationships.

The problem of interpreting the school's program to the community is crucial. Success depends on working through and with existing community organizations, of setting short-range and long-range goals and of involving numerous groups and individuals into an action or an educational program. The parent-teachers association can help bridge the gap between school and community by facilitating the cooperation of parents, teachers and administrators. According to Caldwell and Foster, "growing communities tend to act more rapidly than static or declining communities. Urban communities tend to respond to new appeals more rapidly than rural, and new communities more quickly than old."[5]

The school that is most successful in interpreting its program is the one which involves the community most effectively in programs of joint participation of school and community groups.

### *Coping With Problems*

In coping with the problems of schools and communities through a human-relations program, the best of what we already know concerning democratic practices must be applied along with some new approaches for bringing about adjustment to the changing social and psychological circumstances of our times.

Changes in family relationships, increased population mobility, man's venture into space and new sources of energy, technological developments, and changes in international relations are among the forces underscoring the need for rethinking our basic concepts and heightening the adaptability of our institutions and agencies.

Along with their historic responsibility for transmitting the cultural heritage and inculcating fundamental knowledge in young people, schools are finding it necessary to orient their programs to: (1) a concept of their expanding service role in the community; (2) a perception of the total community as the unit for planning and action; and (3) a belief in a respect for individual personality as the best means of maintaining and realizing the ideals of the democratic life. In such schools the philosophy of education moves toward a perception of the total relatedness and interdependence of all groups and individuals of the community. Some educators are also beginning to recognize that since we cannot rid our society of all tensions, part of our educational efforts must be directed toward helping young people to learn how to cope with tensions.

Surrounding the school are institutions and agencies such as the family, the church, the banks, the communication agencies, welfare agencies, labor unions, and service institutions. Through its administrators, teachers, and pupils, the human-relations-conscious school relates its programs and activities to the services and programs in which these agencies are involved and assists in the development of channels by which the great body of community agencies can help the school to broaden its programs. Such an approach ideally makes it possible for all individuals and groups in the community to gain from the school those specialized services which the school can render them and to bring to the schools services and resources to enrich the school program.

This approach entails knowledge of the community's resources and needs, as well as participation of all community agencies and interest groups in overall community planning for meeting human needs. It excludes narrow consideration of race, creed, or economic position as determinants for participation.

Thus, with the help of the community agencies, the school seeks to develop a community plan whereby the people themselves, on a cooperative basis, undertake to meet their many needs. Schools are not then divorced from the community and the community is not separated from them. Conflicts are at a minimum because those who interpret specialized needs are referring to needs they know at first hand and have the trust of others since they are helping to meet all needs of the community.

This is in harmony with the basic principles of our democratic society. However, experience has shown that in many areas we have not sought to bring about the necessary framework for accomplishing this. On the other hand, research findings on group behavior are being applied to smooth the way for good human relations in numerous practical situations—in school programs, in overall community planning, in planning for housing projects, in police training institutes, in recreation programs, and in the provision of social services. Although many studies of group dynamics present inconclusive and diverse findings, as knowledge is gained in this field reliable techniques for lessening group tensions may be devised.

Much has been achieved in defining the nature of the social and psychological problems in today's society. For example, studies have revealed the detrimental effects of group and individual prejudices on those who hold them as well as on those against whom they are held. The so-called "roots" of prejudice have been determined, and the genesis of prejudicial attitudes in children has been repeatedly observed. Research has demonstrated that prejudice can be reduced and unlearned under a wide range of circumstances.

It has been found that mere contact between groups is insufficient as a technique for reducing prejudice. Much more depends upon the kinds of contacts which the groups have. It is known that under certain conditions, role playing, sociodrama, and so-called "group-retraining" devices can reduce hostility among groups. It can also be reduced in individuals. We know too that the media of mass communication might be used successfully in the reduction of prejudice in individuals who are not deeply committed in their attitudes. It has also been discovered that a high positive correlation does not always exist between prejudice in the individual and discriminatory actions—although prejudiced, the individual, in some social situations, might not attempt to discriminate.

### *Possible Approaches*

A number of constructive methods are available to school administrators for developing good human relations in the school community:

1. Fostering and supporting common purpose situations which can involve cooperation across groups and organization lines.
2. Encouraging students, parents, and teachers to regard the school and community as laboratories in which they can work together to learn about diverse cultural groups.
3. Involving parents and citizens in appropriate school activities.
4. Promoting in-service programs and workshops for teachers and administrators in cooperation with human-relations organizations.
5. Disseminating to the community facts which show the contribution of all groups to the enrichment of American life and to the maintenance of the Nation's vitality.
6. Adding to the school curriculum information about the major contributions of all ethnic groups to the development of our society.
7. Involving students, teachers, administrators and the board of education in periodic all-school evaluations of school practices, use of facilities, and student participation in activities.
8. Encouraging community groups to use the school program and facilities in their efforts to accomplish their purposes.
9. Within the school, placing responsibility for setting and enforcing standards of group behavior on the student group.

These approaches are predicted on the assumption that through the provision of opportunity for living in an environment which demonstrates desirable practices and encourages relinquishment of prejudices and the acceptance of other human beings on the basis of individual merit, prejudicial attitudes may be altered and tensions reduced. The approaches are also based on "belief in a basic fact that each one of us, in order to live his life fully, must feel the sense of personal worth which can come only from being accepted as an equal by those whom we meet in our daily lives." [6]

They are also based on the assumption that we have reached the point in our social progress where most human ills can be prevented. The objective of democracy—to permit each individual to develop to his maximum capabilities—cannot be accomplished by encouraging the individual to become isolated from his fellows or forcing him to live in an environment in which he feels that he does not belong. It can only be achieved if the individual, irrespective of who he is, will have opportunity and responsibility as a member of the community to participate in making the community a better place in which to live for everyone, including himself.

There are hundreds of communities over the land where human-relations problems are at a minimum, where persons of variant ethnic groups live in harmony. To attain this kind of environment in all of our communities means the establishment in each community of an all-inclusive community approach so that every individual knows that he belongs and in so belonging has an obligation to be of service to his fellow man.

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*Changes in the major health problems besetting children call for . . .*

# CHANGING EMPHASES IN SCHOOL HEALTH PROGRAMS

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THE PARTNERSHIP of education and medicine that is essential for a school health program has been expressed in many ways but hardly more simply and directly than in a report of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association.[1] The report lists these functions of a school health program:

1. To appraise the health status of pupils and school personnel.
2. To counsel pupils, parents, and others concerning appraisal findings.
3. To encourage the correction of remediable defects.
4. To assist in the identification and education of handicapped children.
5. To help prevent and control disease.
6. To provide emergency service for injury or sudden sickness.

Each of these components is broad and may have varying interpretations as well as applicability. Their applicability is affected by the kinds of health problems that are predominant today. These are different from those of a generation ago and vary among our communities and even from neighborhood to neighborhood in a city. How to carry out these program functions and what meaning they have for school health personnel will differ widely. Basically they have extensive usefulness.

### *The Need for Change*

However, differences in communities and in health problems are not the only factors which determine the content of a community's school health program. Often these programs continue practices which, though appropriate several decades ago, hardly are effective today since they fail to meet the major challenges of the present generation.

When school medical services started in this country (the first is reported to have begun in Boston in 1894) the control of the spread of contagious and nuisance diseases was the principal objective. This led to medical inspections of children in school. Subsequently major emphasis was placed on examinations for the discovery of physical defects and procedures designed to show parents the need for having these defects corrected. This continues to be the major emphasis in school health services. Such examinations are considered of importance not only for case-finding purposes but also for their usefulness in teaching children basic facts about health and in helping them to develop good health habits. In fact, for many schools, health education is considered the principal reason for having school health services.

Probably the most extensive evaluation of a school health program is the study done in New York City in 1942, known as the Astoria Study.[2] This study

These children are taking an audiometric test for hearing in their classroom. Failure to pass will denote a child's need for further testing and the possibility of his need for medical treatment and special attention from the teacher.

not only pointed out that much wasteful repetitive work was going on, which, year after year, resulted in the recording of more defects, often involving the same children, without adequate follow-up activity, but it also showed the way to a more effective program. The conclusions and recommendations of this study have been widely influential. They are particularly significant for teamwork in that the study demonstrated the effectiveness of the teacher in case finding and the importance of her relationships with the nurse and physician as a member of the school health team.

While not all of the findings of the Astoria Study have equal applicability in all of our communities, several basic questions do. These include:

1. What are the major health problems of children in our community?
2. What priorities should be established in providing health services?
3. What are our community health resources and how effectively do we use them?
4. What is the most productive use of the time of the school doctor, nurse, and teacher?
5. For what children should the school provide physical examinations?
6. How can the effectiveness of follow-up services be increased?
7. What is the relationship of the school guidance program to the school health program?

Answers to such questions as these must be sought both within the school in its policies and administrative procedures and in the relationship of the school to the rest of the community. One administrative question has lately been given increasing attention—that is whether nurses in these programs should more appropriately be employed by schools or health departments.

Many people feel that most school health programs are badly in need of review with respect to their content, procedures, and objectives. Large sums of money are spent in these services, with varying effectiveness. Not enough recognition has been given to the ways in which our health problems have changed. Communicable diseases and other acute conditions are now less important. More attention must be given to the problems accompanying growth and development, adolescence, and handicapping conditions of childhood. This will require increased attention to the functions of the school health team and the most effective use of the team members' time.

### *Medical Examinations*

A brief recapitulation of the history of school physical examinations will illustrate how concepts of school health services have changed, as well as some different points of view regarding them. Twenty-five years ago annual medical inspections of all school children were customary. Subsequently, as education became effective in increasing the public understanding of the importance of controlling communicable and nuisance diseases and of securing medical care early and seeking health supervision for children, the value of medical inspections diminished sharply. Some form of frequent health examination was still considered important in many places, however, and has not yet been given up. As recently as 1945, a law was passed in one State which provides for Statewide biennial medical and dental examinations of all pupils in public and private schools. Examinations of such frequency and such large numbers cannot be done adequately, are wastefully repetitive, and may give many parents as well as school administrators a false sense of security.

School health studies have demonstrated that effective case finding at less cost can be achieved by having 3 or 4 routine examinations during the 8 school years, with parents present, and using various screening tests and the teacher's observations and her conferences with the nurse for selecting children at other times for referral to the physician. The teacher has been shown to be a good case finder. Moreover, the more parents rely on their own physicians for their children's health examinations, the less will be the need for the school to provide it. The extent to which they do this varies considerably, however, and is related to the family's income.

Such a plan for health examinations has been shown to be effective and less wasteful. It enables the school doctor to serve as a consultant to the school and the school health team to concentrate on the more important health problems and on securing adequate care for the children who need it.

Limiting the frequency of school health examinations in this way has led many people to the conclusion that this means that school-age children need a health examination only three or four times. Actually what it means is that it is not practical or efficient for the school to provide such an examination more often.

Studies have been made in Rochester, N. Y., of the value of the examination of first-grade children. Most of these children had had physical examinations in kindergarten, either at the school or in their own physicians' offices, so that little new was discovered. The value of the routine first-grade examinations was, therefore, questionable so far as Rochester was concerned. In other communities the examination on entering school is often the first a child has had in several years.

In Washington County, Md., 1,103 examinations were done in the school health clinics in a 2-year period. The most prevalent health problems were upper respiratory difficulties and behavior problems. A number of serious conditions were discovered which were unsuspected. These included 5 children with rheumatic heart disease, 4 with congenital heart disease, 3 with acute rheumatic fever, 1 with malignant but curable kidney tumor, and a variety of others. The discovery among 1,100 children of more than a dozen with serious diseases would certainly bear out the value of the school health examination program for this county.

Another aspect of the school health examinations has received insufficient consideration. The scope of the medical examination when done in school has limitations imposed on it by the unavailability of laboratory tests as well as the physical surroundings. It is essentially a medical screening examination. Those children who need further diagnostic services and treatment must seek this elsewhere. Would it not be more practical to have these examinations done in a clinic rather than in the school? If the child does not go to his own physician for examination, the clinic can schedule immediately any laboratory studies or further visits, thereby insuring more prompt and effective follow-up.

### *Screening Tests*

What other health services should be provided in the school? While most people feel that ideally the periodic health examination ought to be done by the child's own doctor, screening tests of vision and hearing are best done in school where children are in groups. Visual acuity in childhood often changes rapidly and, therefore, vision tests should be done annually. The Snellen test and the Massachusetts vision test have been demonstrated to be efficient screening tests that are carried out most economically and rapidly with groups of children.[3] Hearing testing should be done every two years routinely, with repeat tests on children who do not pass.

These two tests are of great importance for many reasons, among which is the fact that a child needs to see and hear reasonably well in order to progress in school. Another reason, especially valid in public health and education, is that large numbers of children are involved. Moreover, with adequate attention, progression of hearing loss can frequently be prevented and normal hearing may be restored. Between 5 and 10 percent of children fail to pass audiometry tests. These children are in need of further attention. Because defective vision and hearing are so prevalent and can be readily discovered by screening tests and corrected or improved, screening examinations are of utmost importance.

Other screening tests may be of value in the school health program. Periodical measurements of height and weight may be useful when interpreted properly, and are, of course, one of the oldest procedures in school health. Consideration should be given to making routine hemoglobin determination at intervals as a measure of nutritional efficiency. There are now simple rapid urine tests for diabetes, a condition, however, which is not common in childhood and, therefore, questionable for inclusion in a mass screening program. Routine testing for tuberculosis, especially at puberty, should be employed much more widely than at present.

Another screening device as yet little used in school health programs is the pupil's health history as provided by a parent. In medical education much stress is placed on learning to take a good history, because such a history often provides much useful information. In school health work the history does not receive much attention. In reviewing the Pennsylvania school health program recently, the medical advisory panel stated that "a medical history can be devised that will be useful in detecting a number of different ailments, including allergies, epilepsy, diabetes, infected tonsils, rheumatic fever, mental illness, and orthopedic defects." Such a history was developed for adults by Cornell University Medical School. Known as the Cornell Medical Index, it is being successfully used in the outpatient department of the New York Hospital. A similar history, filled out by the parent, was tested in the California school health program, and found to be reliable and useful to the doctors and teachers, who were very favorable in their evaluation of it.

### *Points for Review*

School health examinations include periodic health appraisal, screening tests, and continuous observation by the teacher, with referrals to nurse and physician. This part of the school health program needs objective review so that the most productive use is made of the time of the school health team, and activities of comparatively little value can be reduced or eliminated. The problem of dental caries is an illustration of this:

Dental caries is a condition which is very common and has received a great deal of attention in school health services. Probably 90 percent of children have dental caries. That being so, little is accomplished by frequent dental inspections. It can safely be assumed that every child ought to go to a dentist at least once a year for dental care. Efforts should be directed to getting this done rather than to provide repeated dental inspections.

It is possible to reduce dental caries in children by 40 to 60 percent by adding sodium fluoride to the water supply or by applying it to the teeth periodically. The reduction in the size of the problem through fluoridization, and attention given to education in dental hygiene and helping children get under dental care would be far more productive than repeated dental inspections. Yet for various reasons there are many delays in changing over to this kind of a program.

School health services staff devote a large part of their time to the follow-up of children who are found to be in need of further diagnostic work and care. Much of this responsibility is assigned to the public-health nurse. This is often one of the weakest parts of the program. How productive the procedure actually is varies considerably and should be analyzed by each program regularly. It is the repeated finding and recording of defects about which nothing gets done that has led to much current concern about school health programs.

Since not all defects are of equal significance, it would seem to be possible to devote time to follow-up on the important ones rather than to all that are recorded. Studies of administrative procedures have resulted in more efficient follow-up. But for the most part the school is dependent on the parents, the child's physician, and other outside resources to provide what is necessary. The extent to which such resources are available and the relationship of the school to them is crucial in this phase of the program. In Philadelphia, of 74,940 reported remediable defects in 1951–52, only 30 percent were treated over a 2-year period. Yet Philadelphia is a city where there are many community health and medical facilities.

It is important that the school health program be administered in close relationship to other health programs in the community and not isolated from them. In Washington County, Md., the program is a joint responsibility of the department of education and the department of health and is regarded as an integral part of the county's organized health service. This has enabled the county to develop a program in which there is a continuity from preschool health services to services in the school and to several specialized public-health programs. The fact that the Washington County health department has a well-organized hearing-conservation program undoubtedly accounts for the fact that recommendations for follow-up care of 430 children with ear, nose, and throat problems were carried out for 92 percent of the children referred. Of 293 referrals for tonsillectomy and adenoidectomy, 195 were carried out by the conservation-of-hearing program and by private physicians. High rates of successful referrals were achieved with other children as well.

Thus, it is possible to achieve considerable success in follow-up care if this is regarded as sufficiently important to expend time and money to do it, in a program which is closely coordinated with other community agencies. Studies have been done which demonstrate that the financial status of the family, the availability of community resources, and the level of education of the parents are significant factors in the parents' carrying out the recommendations of the school.

### *For Handicapped Children*

Perhaps in no other aspect of school health work is the need for genuine teamwork so evident as in services for handicapped children.

Many children have disabilities, often of a chronic or permanent nature, which may create problems in obtaining an education. These are the children who are orthopedically handicapped, children with poor sight and hearing, children who have cerebral palsy, heart disease, epilepsy, allergies, diabetes, and other conditions. Most of them can be educated as readily as other children. But many will need some modification of their educational programs if they are to benefit from educational opportunities. It is generally estimated that about 10 percent of children require special education. These include the physically, emotionally, and intellectually handicapped. There are, of course, many more who do not need special education, but do require special attention from time to time.

In 1930 the White House Conference on Child Health and Protection made this recommendation: "A State program for crippled children should be built upon the rights of individuals to an equality of opportunity, especially from the educational viewpoint. Academic education and prevocational and vocational guidance and training adapted to crippled children should be available to them at all times in which they are physically able to receive the same, regardless of the location of their residence. Physical care and education designed to produce self-supporting and useful citizens should be carried on together."

Most handicapped children can be educated in regular classes or in special classes in regular schools. The trend is clearly in this direction. Special classes in day schools are becoming increasingly common. Flexibility in school administration is, of course, requisite. Such schools must have adequate health and guidance services and teachers with training in the education of exceptional children.

Schools can make a further contribution by making some provision for education in the preschool years. Children with cerebral palsy and children with impaired hearing can benefit greatly by early education. Many so-called deaf preschool children, with a proper diagnosis, a hearing aid, auditory and speech training, and training in lip reading, will get much more out of school if they have the advantages of special training in a nursery school. Such children today are often subjected to needless segregation in a residential school.

Epileptic children on the other hand are commonly excluded from school altogether. Most of them do not need special education, but they do need a chance to go to school with other children, which they usually are able to do. About 75 percent of epileptic seizures can be controlled by medication. Even if a child does have a seizure in class no one is harmed by this if the teacher is calm and helpful. The teacher's attitude will set the stage for the attitudes of the children.

The placement of children in special classes requires expert medical and educational judgment and should be done only after careful diagnostic work. Children who are in special classes should be examined periodically to see whether such placement is still necessary. A review of children in special classes done in New York City revealed that 58 of 182 in sight-conservation and Braille classes, or 31.9 percent, were inappropriately placed. Fifty-four of these were reported to belong in regular classes. In the same study, of 74 children in cardiac classes, 87.9 percent "probably did not require placement in the special classes." The report further states that "modifications of the school program * * * should be individualized in terms of the changing needs of individual children. The primary objective should be to return as many children as possible to regular classes in as short a time as possible." [4]

Another aspect of school health which is receiving increased attention is that of the social and emotional development of children and the problems which sometimes develop. These may be more common today or we may be more interested in them. The teacher is in a good position to recognize attitudes and behavior in younger children which may be suggestive of the later development of delinquency.

More adolescent children are reported by the juvenile courts to be in difficulties than in the past, and this places on us a responsibility for dealing with these problems. The school social worker, or visiting teacher, is concerned principally with children whose behavior, attitudes, or family situation are such that they require special attention if they are to benefit from their educational opportunities. The school social worker is frequently able to assist the school staff in improving the child's school adjustment. When the pupil is to be referred to community social agencies or comes under the care of the juvenile court, the social worker is involved. This aspect of the school health program is taking on increased significance in many urban areas. Although often considered a part of the guidance program rather than the school health program, little reason exists for continuing to separate them.

### *For Adolescents*

The problems of adolescents are especially pertinent to the health programs in secondary schools. There is a greater interest in adolescence than ever before. In fact some people believe that just as the period of infancy and early childhood formerly received a concentration of attention in pediatrics and public health, so we are now moving toward the adolescent and devoting more time to his problems of growing up and seeking independence in our ever more complex society. In adolescence psychologal problems take on greater significance. As teenagers are apt to look elsewhere than to their own parents for guidance, the schools through counselors and others often have an opportunity to be helpful to them.

Many parents are unprepared to cope with the various phases of adolescent development. For many years health workers have emphasized anticipatory guidance for parents of preschool children, but only recently has it been suggested that similar guidance might be offered to parents of pre-adolescent children.

An obstetrician, Dr. Samuel Kirkwood, Commissioner of Health in Massachusetts, recently stated, "Of all times in the life span of a woman, most difficult is this jump from girlhood to womanhood and the responsibilities of physical reproduction. Literally overnight the young girl becomes a totally different person. She is no longer the same to herself. Her position in the family is as changed as her place in the community. She looks at no one, and no one looks at her, in the same light as before the event of puberty. Our civilization places great restrictions upon her and we give her at best little help in this trying time. Only intelligent, sympathetic support can resolve the conflict of necessary dependence and equally necessary self-assertion which marks this time of life." [5]

The concern of the previous generation of health workers was directed to the problems of maternal and infant mortality. A more positive purpose is expressed by Dr. Kirkwood in his concern for healthy children and healthy families. Many obstetricians and pediatricians today believe that the most strategic time to prepare for satisfactory childbearing and childrearing is during the period of adolescense. In accepting this opinion health services, health education, and health counseling must be coordinated in more effective ways to capture the interest of adolescents in preparing to meet their responsibilities of the future.

Dr. Roswell Gallagher's adolescence clinic in Boston represents a pioneer effort to deal more constructively with the young adults of this age period. Similar clinics are in the process of development elsewhere. Problems of adolescence may well be the major challenge of our generation, just as infant mortality was for the previous one.

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**Mental health is not measured by earning capacity, but by happiness capacity.**

*Henry A. Davidson, M. D., in the* New England Journal of Medicine, *October 3, 1957*

*Some signs of approaching danger*
*of which professional persons*
*need to be aware in . . .*

# HELPING PARENTS OF HANDICAPPED CHILDREN

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FEW, IF ANY, parents know instinctively how best to help a handicapped child, and how best to handle the intense feelings of disappointment, guilt and resentment which pour over them when they realize that their child may never walk or talk, or learn, or love as other children do. Learning to live with their handicapped child, and with their feelings about him, imposes upon parents the necessity for tremendous spiritual growth and intellectual understanding. This does not come overnight. Finding out what the child needs and how to give it to him is a slow learning process. Parents need wise and patient guidance if the lesson is to become an integrated part of their thinking and being.

Handicapped children belong to emotionally healthy and mature parents and to neurotic and insecure parents. Most often they belong to average parents who are able to withstand a moderate amount of stress and strain, but who may develop serious problems of adjustment if the stress becomes very great. In other words, the typical parent of a handicapped child is, like most of us, a person who can take just so much and no more. This parent is subject to great emotional strain, which may affect his ability to plan appropriately for his child and himself unless relief in the form of counseling and other professional services is available.

Severely handicapped children do not, like normal children, "just grow." The growth of a normal child is governed by an inner law of development. The child will "just grow"—as a physical being and as a personality—if granted a reasonably favorable physical and emotional environment.

But the inner law of development which governs the growth of a child who was born with cerebral palsy, for example, has lost its reliability. Who, then, knows how it will operate? Certainly not the child's poor parents—at least, not at first. They are apt to be average—not exceptionally bright, not exceptionally slow. They are familiar with the way their average children grow, and they are doing fairly well by them. But what now? Their little girl is 18 months old and she does not even crawl, or say "mama," or feed herself cookies. The doctors say she will probably always be handicapped, but hasten to add that there is much that can be done to help her.

It is that word "much" that does it. Remember, the little girl's parents are the kind of people whose tolerance for stress is just average. They can take so much but no more. And here comes much more—hours of exercises, speech stimulation, assistance in feeding and dressing, plus days and weeks of discouragement and frustration when there seems to be no tangible reward for such a great investment of effort. The goal? Well perhaps the little girl may, at some far distant day, reach that goal her brothers and sisters achieved without even trying—functional independence.

On whom will the final responsibility for achieving this goal rest? Not on the child alone; only partially on doctors, nurses, social workers, and therapists. It will rest chiefly, in the long run, on the child's parents. They are the ones who must face the major responsibility for stimulating artificially the physical and emotional development of a child whose natural potentialities for development have been disastrously tampered with. No wonder that a handicapped child's parents often say, in one way or another: "This is too much to ask of me."

### *Parents as People*

There are many ways in which parents of handicapped children say "This is too much." Social workers and nurses have heard them all again and again.

When a parent of a handicapped child says, in effect: "But I have my own life to lead," he means that the burden of his handicapped child is becoming too heavy and that he is asking, however indirectly, for help. This reaction to stress is sometimes labeled "parental rejection." On the surface that is what it seems, but the professional person who looks further may find that it is a fairly wholesome response to an almost intolerable pressure.

Twentieth-century American parents who read a great deal about child care in the periodicals are likely to come to the conclusion that our society regards them as less important than their children. Our child-centered culture expects parents to make great sacrifices in order to provide their children with "security"—that "elusive" goal of modern living. So saturated are most of us with the concept of the almightiness of the child, that we recoil when we hear a parent protest: "But I have my own life to live!" When we hear the parent of a handicapped child say this, we recoil further. "How selfish and self-centered can a parent be?" we ask.

A professional person should not be dismayed when a parent of a handicapped child protests: "But I have my own life to live!" After all, he speaks the truth. He is right, and he needs to be told he is right. He cannot be a good parent if he does not have some of the satisfactions and rewards which he needs as an individual in his own right. He cannot give up his whole life for his handicapped child and expect to be a well-adjusted, self-respecting, contributing member of society.

Professional persons must accept the task of lightening the load for such parents and giving them a chance to be free—free of guilt, remorse, and resentment and free of a 24-hour-a-day schedule of child care and therapy. We can say, in effect: "You do have your own life to lead, and you should be free to lead it. We will help you by sharing the physical burden, by giving you knowledge of why and how this happened so you won't feel so badly about it, and by finding adequate financial assistance for you so that the cost of medical care will not leave you bankrupt."

This approach involves the professional person in a threefold responsibility:

1. Sharing the physical burden may mean helping the parents secure admission for the child to a treatment facility, a hospital school, a special camp, or a day center. In some instances, it may even mean helping the parents to make a decision in favor of permanent institutionalization and acquainting them with appropriate facilities for long-term care. In either event, the professional person must share with the parents a sound knowledge of the resources available for handicapped children and must pave the way toward referral.

2. Supplying the "know-why" and "know-how" involves the professional person in individual or group counseling with the parents, usually over an extended period of time. In some cases, this may require the combined efforts of a professional team, including doctors, psychologists, social workers, and parent-education specialists. It also requires the professional person to participate in public-information campaigns.

3. Securing adequate financial assistance for the care and treatment of a handicapped child means that the professional person will probably have to refer the parents to the services equipped or responsible for meeting their needs. This may be a clinic for crippled children, run under public, semipublic or voluntary auspices, where medical care can be secured free or at low cost; or a local welfare department, service club, or voluntary social agency which can help out with the expense of braces, wheelchairs, prostheses, or other appliances.

Such services can go far toward restoring to a parent his own life to lead as he sees fit. They do not take from a parent any of the rights or responsibilities which are inherent in his parenthood. They merely give him a little more time, a little more assurance, a little more security, which he can share with his family and his community. Everyone benefits, particularly the handicapped child.

### *Unsure Parents*

Some parents have another way of saying that they need help. They say, "I do not have the patience to work with a handicapped child. I cannot give my little boy what he needs. I am too nervous."

A professional person who looks behind this statement may find that the child's parents are young and unsure of themselves, and that grandma, experienced and very sure of herself, has taken over: she compulsively follows every order the doctor gives; having hours to devote to the child, she decides he might as well live with her and benefit from her determination and devotion; she exercises limbs, she fortifies diets, she stimulates speech; she does everything.

In such a situation, the young parents feel more helpless than ever and decide that they can never be as adequate as they must be to meet the child's needs. They have had so little chance to get to know their own child that he is a stranger to them. They find it increasingly difficult to find a place in their lives for him. Eventually, he is deprived of normal family experiences, his parents feel guilty about their rejection and withdrawal, and grandma continues to overprotect him because of her own need to control and dominate. For this little boy personal relationships are badly snarled. He gets his therapy daily and his vitamins every morning. But he does not know who he is or where he belongs, and his disposition is deplorable.

This illustration does not mean that grandparents are not useful and necessary to the family of a handicapped child. It means, however, that there are grave dangers for the handicapped child inherent in any situation which takes ongoing responsibility away from the natural parents.

A similar situation sometimes develops when a handicapped child is placed in foster care by official authorities because his own parents are neglecting his physical care. Like grandma, the foster parents may be determined to do everything just right. But foster homes often fade fast, since the care of handicapped children is more demanding than many foster parents ever dream. So these children all too often lose their foster parents. Who then takes their place? Who has been growing up to the ongoing responsibility of meeting their emotional needs? Not the parents—they have no permanent responsibility, and know it.

The truth is, no one has grown up with the problem. The child's own home is lost; the foster home is lost; the child, unfortunately, is probably lost, too. Too late we may recognize the hard, cold fact that half a home of his own is better for the child than no home at all, and that ineffective parents are better than none. The professional person's task is not to find new parents for handicapped children—except in rare instances, substitute parents just don't work out on a long-term basis—but whenever possible to help natural parents with their load so that they will be better able to carry it.

Moral support is what insecure parents need and the offer of concrete services together with recognition that they have a hard row to hoe. Once granted respect by the community and relief from the burden of ignorance and debts under which some of them stagger, these parents often show a remarkable ability to handle responsibility which might once have been taken away from them.

### *Denial of Reality*

There is a third way in which parents of handicapped children tell us that they are beginning to crack under the strain of their responsibility. With what appears to be unrealistic optimism they say, "Billy is doing just fine. We are pleased with his progress."

Denial of reality as a reaction to stress is found among the parents of severely handicapped children, and especially among those whose physically handicapped children are also mentally retarded. During such a child's infancy, his parents may have gradually learned to accept the fact that he is crippled. But this seems to be as far as they can go. As the child advances in chronological age but fails to advance mentally, the parents cannot accept the additional stress of a second disability, and, although they have been told repeatedly that their child is mentally retarded, they say, "We are convinced that our little boy is a bright child. It is only his physical handicap that holds him back."

It is true that the parents of the handicapped must have help. But it must never be given in a patronizing "I know better—now you listen to me" way. In the final analysis, the parents know their child better than the professional person does and they'll probably tell the truth about him if given a chance, for a defense usually crumbles in time before a truly sympathetic listener. They'll need to be absolutely sure they are not in disrepute for past shortcomings, or that an honest confession will not be used to cut off their access to services. The professional person who understands that "he is doing just fine" is merely a defensive verbal barricade against deeply feared reality and not the expression of an unshakable conviction, will be better able to help.

Of course, there are parents whose denial of reality becomes so extreme that only intensive psychotherapy can help them. The professional person has to find out how severe this reaction is before he can judge whether or not it can be handled successfully without psychiatric help. Nurses and social workers know that they are not competent to treat severely aberrant reactions in the parents they seek to help. But recognition of their limitations should not block them from doing what they can to ease anxiety in deeply disturbed parents. They need never be afraid to listen sympathetically to persons in distress. This may not help, but it will never hurt. Afterwards they will want to consult with a competent psychiatrist about the next step to take.

### *The Hopeless*

Not so different from the unrealistic optimists are the unduly pessimistic parents who say, "It's a lost cause." They are afraid to be hopeful lest their hopes be dashed. Fearing that they cannot sustain the emotional stress of another disappointment, they say, "We expect nothing. If progress occurs in our child, we'll regard it as a miracle."

These parents react to stress with a defeated attitude; they are afraid to keep trying. A professional person should remember that when the parents of a handicapped child sound a note of defeat they are probably trying to defend themselves against an overpowering fear. He should let them know that *he* knows how hard it is to be cheerful in the face of cruel disappointment. But he must turn the focus to the hopeful facts—the child's strengths, his potential for improvement. He should offer services and let the parents know that a treatment center, a hospital school, a speech correctionist, or whatever is needed will share the burden of their fears and help them make appropriate plans for their child's habilitation. In such cases, nothing succeeds like success. When such parents learn about their child's potentialities and about the services available and see the child improving under appropriate treatment, the truth frees them of their fear of failure. But always the professional person must remember never to deviate from the truth, never to hold out unjustified hope.

### *Projection and Withdrawal*

There is a fifth way in which parents tell professional persons that they need help. They say: "It was all the doctor's fault. He was careless when the baby was born," or "He should have known I was RH negative. The baby should have been transfused at birth," or "It runs in my husband's family."

Some of these parents are factually right. Some are very wrong. But whatever the facts, they are reacting to stress by projecting blame for the cause of their predicament upon someone else. This relieves them of a sense of full responsibility for their own actions and attitudes, and so stands in the way of their planning a sound program for their child. Such parents need the kind of counseling which can help them express their feelings and free themselves of any sense of guilt they might have in regard to the child's retardation.

There is yet another way in which parents of handicapped children tell professional persons that they need help. They simply do not say a word. They withdraw into their shells and do not talk about their child. They seem ashamed and sometimes even try to hide their imperfect child from the world to avoid embarrassment. Such parents are saying, in their silent way, that they cannot carry the weight of their shame about their inability to produce a normal child. They see their offspring as a product of their own imperfections. The child is a constant reminder of their inadequacy. Lest this inadequacy be paraded before the world, the parents keep themselves and their child from society and the child grows up without normal social experiences.

In its extreme forms, this type of withdrawal indicates deep-seated mental illness. In milder forms, the warm support of a professional person can do much to encourage such parents to make normal social contacts for themselves and their child. "Ego-supportive treatment" is the term social caseworkers use to describe the process which seems to be most helpful in relieving the anxieties of those who tend to withdraw. The parents are warmly approved for any positive steps they make toward regaining contact with society. They gain confidence in their own worth from the knowledge that their doctors, nurses, and social workers like them, esteem them, and care about them as individuals. With more self-assurance, they begin to appreciate the worth of their child, however handicapped he may be. Having learned to relate in a new way to a person whose friendship offers them longed-for security, they find confidence to face the world.

### *Guilt Reactions*

Some parents indicate when the strain of their burden is becoming too great by showing feelings of guilt in regard to the child's handicap. "I blame only myself," they say. "It is not the child's fault."

Some of these parents know why they feel guilty. They tell about not having secured proper medical care for a sick baby, or having allowed the child to go swimming during the polio season, or not having followed diet instructions during pregnancy, or having taken the child to a chiropractor instead of to a physician. Others are pervaded through their whole being with a sense of guilt, the source of which they cannot name. The guilty feeling, then, may stem from deeply buried fears of religious or sexual error, the child's handicap being regarded as a punishment from God for the parents' sins.

To care for a crippled child under a heavy burden of guilt is a heavy task. The guilt-laden parent needs immediate help. He needs counseling, education, services—everything that will help him regard the handicapping condition not as a punishment but as an accident. When his energies are no longer totally invested in inner conflict but free to make plans and find care for the child, then the whole family, including the handicapped child, stand to gain immeasurably.

### *Parental Attitudes*

These are a few of the ways in which families of handicapped children give warning that they are faltering under their burden and ask for help. Let us hope that the ears of doctors, nurses, and social workers will be tuned to hear the true meaning of what is being said, and that their professional services will be broad enough and flexible enough to meet the needs. For if the families of handicapped children can be salvaged the children can probably be salvaged, too. But if the parents are lost, the cause is lost.

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# FILMS ON CHILD LIFE

**Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.**

KAREN. 20 minutes, sound, color, rent; in Texas, loan.

Explains each step in using an audiometer to give hearing tests.

*Audience:* Teachers, nurses, and parents or other volunteers learning to give hearing tests.

*Produced by:* Texas State Department of Health, Public Health Education Division, Austin 1, Tex.

*Distributed by:* Same.

ARTS AND CRAFTS FOR THE SLOW LEARNER. 27 minutes, sound, black and white, purchase or rent.

Shows various types of manual activities in a public-school class for the educable mentally retarded—finger painting, woodwork, leathercraft, potato carving, wet-chalk drawing, glass painting, and wood burning.

*Audience:* Teachers and parents of retarded children.

*Produced by:* Nathan Wolfe, Alfred Schmidt, and Melvin Schumacher.

*Distributed by:* SWS Educational Films, 744 North Fuller Avenue, Hollywood 46, Calif.

EVEN THE LEAST OF THESE. 12 minutes, sound, color, rent.

Pictures activities in a school for cerebral-palsied children. Shows the kinds of services and equipment needed in helping these children overcome their handicaps or adjust to them.

*Audience:* Parents; civic groups.

*Produced by:* State College of Washington, under sponsorship of the Eastern Washington Society for Crippled Children.

*Distributed by:* State College of Washington, Audio-Visual Center, Pullman, Wash.

NO EASY ANSWER. 18 minutes, sound, black and white, purchase or rent.

Raises questions for group discussion of how Jewish parents can deal with the effects of anti-Semitism on their children.

*Audience:* Parents.

*Produced by:* Anti-Defamation League of B'nai B'rith in cooperation with Department of Child Study, Vassar College.

*Distributed by:* Anti-Defamation League of B'nai B'rith, 212 Fifth Avenue, New York 10, N. Y.

# COORDINATING HEALTH SERVICES FOR HANDICAPPED CHILDREN

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ALMOST ANY community with a strong interest in fostering rehabilitation of handicapped children eventually faces the problem of coordination of services.

The problem, in fact, actually reflects the vitality of the community's interest, for it exists only where concern for the handicapped has resulted in the provision of a number of services by a variety of agencies. Communities with little interest and consequently few, if any, services have nothing to coordinate.

Handicapped children fall into many diagnostic categories. They include: children with orthopedic, neuromuscular, and neurological problems; children with rheumatic fever or heart disease or both; children with congenital malformations or birth injuries of all types; children with convulsive disorder; children with cleft palate and cleft lip; children with hearing impairment; children with visual defect; children with malocclusion; children with speech defect; children who are mentally retarded; and children who are emotionally disturbed. An increasing number of State or community programs for handicapped children are including children having any type of chronic illness, including, among others, diabetes, nephrosis, asthma, and celiac disease.

With so many diagnostic categories included in the definition, the total number of handicapped children is bound to be large. Accurate data on the number in this country are not available, but conservative estimates put the total at 5,615,000.[1] The largest groups are composed of children with speech defects, orthopedic conditions, mental retardation, rheumatic fever and heart disease, and hearing impairment.

The types of services needed by handicapped children in any of these categories are also many and varied. They include: (1) early case finding; (2) referral and counseling; (3) evaluation, diagnosis, treatment, and rehabilitation on a team basis with consideration of health, social, psychological, educational, vocational, and recreational aspects; (4) provision of opportunity to continue either in regular school classes, special classes or special schools, or with home teachers, according to the child's condition; (5) provision of vocational testing, guidance, training, and job placement for teen-aged handicapped youth; (6) provision of recreational opportunities, including day programs and camping; (7) provision of foster-home placement for those who need it; (8) provision of home-care help for homebound children; (9) provision of special housing for some handicapped children and their families; (10) special transportation facilities to enable some children and young people to attend school, recreational programs, treatment services, or work; (11) residential or custodial care for severely disabled children who show no evidence of response to the rehabilitation process over a period of years.

A well-rounded program for the handicapped will also be concerned with the kinds of health and educational programs that can prevent further handicapping conditions from developing either in normal children or in children already handicapped.

Obviously all of these services must be of high caliber if the broad rehabilitation of handicapped children is to be achieved. Moreover, they are as applicable to children in any one of the diagnostic categories as to those in any other. However, few, if any, of the handicapped children of any diagnostic category will need *all* of the services listed. Some children will need only a few services; others will need many.

## *Why Coordination?*

The association between chronic illness and medical indigency is well known. It means that most low-income families and many middle-income families with handicapped children need assistance at some point in the various stages of their rehabilitation. Therefore, the community must be prepared to carry the financial responsibility from both official and voluntary sources for a large share of the services for the handicapped. While services to handicapped children have a strong fund-raising appeal, nevertheless sufficient funds never seem to be available to do a complete job in all aspects of service for all those needing service.

Care of handicapped children is expensive, particularly where services are developed on a team basis, as is currently recommended. For example, in a service for children with cerebral palsy, an effective team contains these essential members: pediatrician; orthopedist; physiatrist; social worker; public-health nurse; physical, occupational, and speech therapists; psychologist; teacher; and vocational counselor. To their services may be added those of an ophthalmologist, neurologist, psychiatrist, and hearing specialists. In a service for children with hearing impairment, a fully staffed team includes: pediatrician; otologist; social worker; public-health nurse; speech therapist; psychologist; teacher; vocational counselor; audiologist; and audiometric technician.

**Two children practice motor control through a normal nursery school activity in a pre-school center for cerebral palsied children. Referring parents of handicapped children to suitable services is a first step in helping them.**

Obviously, for the community to employ a complete team for handicapped children of each type would involve considerable expense as well as duplication, for both teams require some of the same types of personnel. This aggravates a serious problem posed by a scarcity of trained personnel. A recent report of the Health Resources Advisory Committee [2] indicates a shortage of trained personnel exists in practically all of the professions necessary for the rehabilitation of the handicapped. Therefore, from the viewpoint both of conserving funds and reaching as many as possible of the children who need help with the personnel available, joint planning and coordination of services are necessary.

Where there is no joint planning and coordination among the services for handicapped children, continuity of care is not always provided, not all children receive all of the services they need at the time most appropriate for them, and multiple diagnostic workups are often performed which are both distressing to the patient and wasteful of professional time.

## *Methods of Coordination*

Agreement on the need for joint planning and coordination of services immediately brings up the question: "What are some possible methods by which coordination can be accomplished?" This can be approached at two levels—community organization and the direct provision of care to the individual child and his family.

Let us look first at the community. For my first two years as director of a crippled children's program in a large metropolis, I spent a considerable amount of time with my staff in looking at the services available, determining unmet needs, and attempting to plan new services to meet those needs. While we managed to secure a great deal of information, we had little or no success in developing new services. This was highly discouraging. However, as we went around to look at the services that were available, we became acquainted with a number of staff members of the four other official agencies and about 25 to 30 voluntary agencies serving handicapped children. We found that the representatives of most of these agencies had the same types of problems and had recognized many of the same needs that we were beginning to recognize. We also found that each one of us had been trying individually to develop services, with hardly any tangible success. As a result, a meeting of all agencies serving handicapped children was called to see what the group could accomplish together. It turned out to be the first of continuing regular monthly meetings.

At the first meeting, the conferees selected priority items from a long list of unmet needs. Then they went to work through subcommittees, drawing up statements of the need and recommendations for a community plan.

Through this joint planning, the agencies achieved the following accomplishments:

1. A jointly financed study of transportation of the handicapped, which took 6 months. This resulted in the revamping and improvement of the entire method of transporting handicapped children to school.

2. The development of a plan for services for handicapped children of school age, which was the basis of recommendations to the mayor made by a special advisory group appointed by him for the purpose. As a result of these recommendations, services were expanded to enable many more handicapped children to attend school and to receive more complete service at school when they did so.

3. A statement of housing needs of families with handicapped children. This resulted in some priority being given these families in assignment of apartments in new low-cost housing projects.

4. A recommendation that a foster-home program for handicapped children be developed. While the child-placement agencies in the community did not completely follow this recommendation, they did take an increased interest in finding foster-family homes for handicapped children so that more such children were placed in them from hospitals and convalescent homes.

5. A recommendation that the official crippled children's agency pay for outpatient care of handicapped children. Some initial success in this direction has been followed by increased attention to the problem.

6. The development of a plant for a home-care program for the homebound. Implementation of this plan has been impeded by lack of a source of financing.

7. An agreement by the agencies to review together the annual budget request of the official crippled children's agency and to select items in it they wished to support. As a result, representatives appeared at budget hearings to speak in behalf of the request and did a great deal of "behind the scenes" work to get the budget adopted. This support was largely responsible for whatever success was achieved in the development of new services in the official budget.

This particular method of coordination—consisting of monthly meetings of all community agencies concerned with handicapped children, their agreement on the most important unmet needs, their working out of a joint plan, and their pulling together to promote its adoption—was carried out entirely informally. When agencies were asked if they would like to have some official recognition for their joint work, they turned it down on the theory that the informality of their efforts gave them more freedom of operation.

### *Committees and Commissions*

A formal extension of this method, which has met with considerable success, is the establishment of a statewide or community crippled children's commission for handicapped children. Such a commission usually has advisory functions only and is composed of professional and lay persons interested in developing, promoting, and coordinating services for all types of handicapped children.

Another method for coordinating efforts for handicapped children is the establishment of a joint legislative committee on handicapped children, appointed by the Governor and composed of selected legislators, professional personnel, and lay leaders. In New York State a joint legislative committee on cerebral palsy, established at the instigation of United Cerebral Palsy, has accomplished a number of objectives, including appropriations for: a study of the number and needs of children with cerebral palsy; the training of all kinds of professional personnel; grants to institutions giving out-patient care to cerebral-palsied children; expansion of inpatient service in one State institution. The committee annually reviews the service data, caseloads, budgets, and budget requests of the four State de-

A nursery school teacher and a physiotherapist help two children with cerebral palsy learn how to fall without getting hurt. Numerous other specialists complete a team providing coordinated services to such children.

partments of government concerned with cerebral palsy—health, education, welfare, and mental hygiene—and makes recommendations to them.

This council has been in existence 10 years. Because of its success, a movement is on foot now, initiated and spearheaded by the United Cerebral Palsy itself, to broaden the council's concern to include all types of handicapped children.

Still another method of coordinated planning is the use of advisory committees for agencies working with the handicapped. For example, in New York City whenever the official crippled children's program is considering the development of an entirely new service, an official advisory committee is formed, composed of clinical experts, representatives of pertinent voluntary agencies and, at times, lay leaders. Facts about the needs are presented, and a recommended plan for community action is usually developed. In this way, the voluntary agencies are brought into the planning early, duplication of services is avoided, and some coordination of agency services is achieved. The reverse also takes place. In New York many of the voluntary agencies have formed professional advisory committees, of which clinical experts and representatives of the official programs are members.

Such close working relationship means that the official programs are assisted in assuming responsibility for many of the basic routine services while the voluntary agencies, with their greater flexibility, can use more of their funds to try out new ideas and initiate pilot programs. Thus, the community can make progress more quickly in taking care of unmet needs, can reach more children and their families in need of help, and can use the funds available for handicapped children in a sounder way than would otherwise be possible.

Such a close working relationship cannot develop overnight. In New York it came about only as workers in the field came to know each other and to develop mutual trust and respect. It required fostering a feeling of sharing a common goal to displace a feeling of competitiveness.

### *Direct Services*

Now, let us look at what can be done to provide coordinated care to the individual child and his family. During the current century, and especially in the last two decades, interest in specific diseases has resulted in the establishment of so many voluntary organizations on a diagnostic categorical basis that in many communities today services to the handicapped are provided through numerous separate agencies. It is not uncommon to find in one community separate agencies for patients with cerebral palsy, muscular dystrophy, multiple sclerosis, cardiac problems, convulsive disorder, mental retardation, arthritis, and hearing impairment.

The provision of these services for the various kinds of handicapping conditions separately can have a number of undesirable effects. For example, in the care of cerebral-palsied children, it may mean that a cerebral-palsied child suspected of having a hearing impairment will either receive an inadequate hearing evaluation in the cerebral-palsy service or be referred to another agency for hearing service. Or if the same child has convulsions, he may not achieve full control of his seizures through the special cerebral-palsy service and may have to be referred to another agency serving children with convulsive disorders. This would again be true if he had a visual defect or a cleft palate.

Thus, diagnostic fragmentation of services presents the possibility of incomplete evaluations in some instances and of repetition of parts of services in others, and frequently makes it necessary for the child and his family to go from place to place to achieve complete service. For these reasons, as well as to prevent wastage of community funds and of the time and energies of available personnel, it seems sounder to provide such services through a general multidiagnostic, treatment, and rehabilitation agency interested in all types of handicapped children, located in one place and staffed with all the kinds of personnel necessary to meet all the needs of all handicapped children. This approach means that the individual child and his family receive better care, more children are helped, the professional personnel are used more efficiently, and the cost to the community per child is reduced.

### *The Team Approach*

Another coordinating device can be found in the "team approach," a term which has been widely used for years, but not as widely translated into practice.

What can the team approach mean for the individual child and his family? It might mean eventually the difference between an independent and productive young adult on the one hand, and a long-term public-assistance recipient on the other. In other words, in one case, the presence of a vocational counselor as an integral part of a team for handicapped children may mean the application of vocational testing, guidance, training, and placement to the teen-ager at the time when he is most ready for it. In another case, a child who is participating in the rehabilitation process may reach a plateau in his climb toward normality, either because of physical or psychological impediments. The inclusion of a skilled psychologist on the team may make it possible to ascertain the inhibiting factors.

The chances for the child's attaining his maximum potential for rehabilitation will be greatly enhanced if the full team is used for the initial evaluation and for frequent periodic reappraisals. When the team is thus used one member must be designated as responsible for the continuing care of the individual child and his family, to follow the child's progress, and to pull together the team members' various efforts. Without this type of coordination, the team's activities may also be merely fragmented services.

Also important in coordinating services for the individual child and his family is the provision of continuity between care given at a central point, as in an inpatient or outpatient service of a hospital or school, and care at home.

It is not uncommon for a child who has made significant progress on an inpatient service, to regress after returning home. Simple oversights are often behind such regression. The child may have been provided with a wheelchair which is too wide for the doorways at home. He may have been taught to care for his toilet needs through techniques applicable only in the hospital's toilet facilities and not in those at his home. In order to facilitate proper care at home, the community's public health nursing service can be of great assistance in reporting home conditions to hospital personnel, in preparing the home and family to receive the child, and in helping the family to adopt some of the rehabilitation techniques at home.

Each professional worker has numerous opportunities for promoting coordination of health services. These opportunities occur each time he sees a child who is known to other professional workers, as well as when he participates in complex community planning efforts. It is important to bring to the child the particular service he needs at the time most appropriate for him in relation to his individual growth and development. Unless services are coordinated, obstacles may obstruct this essential factor of proper timing and so prevent the best possible job from being done for him. The goal of coordination of services for handicapped children is the maximum rehabilitation of as many children as possible, using the available professional personnel to their fullest, with the least possible cost to the community.

### *The Import*

With the increased aging of our population, health personnel of all types will in the future be more and more concerned with the care and rehabilitation of adults with chronic illness. Some lessons may be drawn from experience in working with children with chronic disease, so services for chronically ill may not have to go through many of the trial-and-error methods which the children's services have had to do. This not only applies to the problem of coordination of services for adults in the community. It also raises the question of coordination of services for children with chronic illness with the newer services being developed for adults with chronic illness. Anticipating this may help us avoid the complication of the problem by approaching it too late.

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[1] Rusk, H. A. and Taylor, E. J.: Physical disability—a national problem. American Journal of Public Health, October 1948.

[2] Health Resources Advisory Committee: Mobilization and health manpower. II. A report of the subcommittee on paramedical personnel. *In* Rehabilitation and Care of the Chronically Ill. Washington, D. C.: Office of Defense Mobilization, January 1956.

*Potentialities for rehabilitation in training schools lie in . . .*

# THE ROLE OF INFORMAL INMATE GROUPS IN CHANGE OF VALUES

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THE GROUP NATURE of much delinquency is an important point from which to examine the treatment process in training schools for delinquent youth. It reminds us that the behavior of individuals is strongly influenced by their group membership and by the interplay of the various groups to which they belong.

Such a paucity of research data is available from the field of corrections that what I have to say can be presented only as suggestive of researchable hypotheses. My theoretical propositions are drawn largely from experiments carried on in the fields of industrial relations, group dynamics, and small-group research, rather than from the field of corrections.

An individual's adherence to social norms is determined not only by the initial internalization of values but also by interaction with other individuals adhering to the same values. The group, in other words, has a definite effect on the persistence or change of norms which complements the psychodynamic forces working within the individual.

In a training school for juvenile offenders, most of the residents are adolescents. While they are there because of having violated the law, they nevertheless share a large part of the values of society or at least of society's subcultures. Their delinquent behavior encompasses only a small range of their total behavior. The training school exercises a custodial and reformative function and, regardless of its philosophy, provides an authoritarian setting. That is, the administration does not exist by or depend on the consent of the residents and is the sole determinant of policy for the institution.

Within the training school an interaction of two groups, the administration and the inmates, is constantly taking place. Between these groups is a line of cleavage defined by a differentiation in status, which is reinforced by the difference in status between delinquents and representatives of the law outside the institution. The integration within one social system of two such different groups, as in an institution, contains many facets not found elsewhere in a democracy:

1. The inmates and the administration are so separate in status that rising from the lower to the higher is an impossibility.

2. While the administration has a specific task orientation, the inmate population does not share this nor have any specific task orientation of its own. Predominantly membership- or group-

**"Inmate" is a word generally avoided in reference to children and adolescents. The author uses it in this article to distinguish those for whom the institution exists from those who run it.**

**This article grew out of a paper presented at an advanced seminar on authoritative settings held at the New York School of Social Work in December 1956. It will be followed in the March–April 1958 issue by another of the same origin, in which Lloyd Ohlin, professor of sociology at the school, describes an experiment in the reduction of role conflict in an institution's staff.**

oriented, the inmate population has no group goal which the young people recognize as valid and achievable through their own coordinated efforts. Moreover, both administration and inmate population maintain networks of informal organization among their memberships.[1, 2]

This informal group structure arises out of needs generated within the institution and within the subcultures from which the young people have come. It is based on:

1. Adolescent needs for peer-group relationships, generated by the conflicts that adolescent status in our society produces.

2. The normal tendency for people spending extensive amounts of time together to cluster into informal groups on the basis of affective ties.

3. The need of persons in the same boat for support from one another. In this sense, the inmate social system has many of the aspects of a minority group under stress.

4. The adolescent need for friends of one's own sex in a culture in which heterosexual relations in childhood and adolescence are generally frowned upon.[3]

## *The Role of Informal Groups*

The informal groups tend to maintain their identity, their norms, and their cohesiveness for, since they serve the needs already mentioned, their persistence is consciously and unconsciously striven for by the membership. Some of their mechanisms for survival explicitly threaten or violate discipline in the institution; others do not and therefore are often considered not particularly noteworthy. On the whole, however, the self-maintenance of the group is synonymous with the maintenance of the value system of its members. This fact tends to defeat the reformative aims of the institution. This is so even when the groups conform in large measure to the demands of the institution.

Among the mechanisms of group control which these informal groups share with other groups under stress are:

1. Recruitment and screening of membership and transmission of the institutional lore to the newcomer.

2. The development of social norms and rituals—characteristic institutional slang, ritual forms of interaction, the sharing of secrets with respect to illicit activities, and the establishment of a definite hierarchy of leaders and followers.

3. The application of sanctions to violators of the group code, ranging from gossip and ostracism to outright violence.

4. The development of loyalty and group ties.

5. The constant reinforcement of the separateness of the group through an attempt to create an orthodoxy of beliefs. This is done by informal communication, the spreading of news through the grapevine, and biased interpretation of the administration's policy, especially where it concerns the fate of particular group members.

## *Obstacles to Change*

As indicated, the informal groupings in training schools for juvenile delinquents not only fulfill many of the inmates' basic needs but tend to become self-perpetuating with the development of mechanisms of group control and group maintenance. They militate against change in the delinquent's value system and against true rehabilitation of those individuals who throughout their stay remain attached to this type of social organization. In the absence of reliable research data, the author, from personal experience in training schools, would estimate this group as comprising from 30 to 50 percent of the inmate population.

While the obstacles to change differ from person to person, depending upon past experience and character formation, these informal groups in general present conditions which are often hampering to the best efforts of individual therapy. Psychological and sociological research has shown that the stabler the frame of reference of an individual, the more resistant is he likely to be to a contradictory frame of reference, and that the stability of a frame of reference depends not so much on the individual's own experience and reality testing as it does on group consensus and reinforcement.[4, 5, 6] This reinforcement of an existing frame of reference makes it extremely difficult for an individual to change even when he has considerable ambivalence in his feelings toward his group. The group always has mechanisms for displacing intragroup hostility onto outsiders.

It is, then, not surprising that so many failures occur among training-school alumni. To blame this on the environment to which the delinquent is sent after release is begging the question, for he will select those associations which are congenial to his character and values. It is likely that in many cases the individual, unchanged by his training-school experience, seeks out a delinquent environment upon release.

## *The Task of Change*

The accumulating evidence that persistence and change of norms are not solely a factor of the individual's own personality structure, but also depend on successive group affiliations and on the resolution of conflicting loyalties in these affiliations is of crucial significance for training schools. What seems to work so effectively in the maintenance of antisocial values could, if the theoretical assumptions are sound, also work in the opposite direction. Evidence that the group can effectively change the individual's value system has been produced by a variety of social-psychological experiments in laboratories and a number of studies in actual life situations.[7, 8] The common element in all these studies is that the individual's frame of reference, attitudes, and value system experience a change under group influence if the individual desires acceptance in the group with which he has been brought into contact. Most delinquents who enter training schools want to be accepted by their fellow inmates.

Therefore, if we wish the young person upon his release from the training school to become integrated into a peer group that pursues constructive aims and does not violate the law, we must somehow prepare him in the training school for such group affiliation. A mere environmental change, such as a foster home, will not be sufficient if the individual emerges from the training school unchanged.

Bringing about change, therefore, would require producing within the institution an informal peer group which is not focussed on hostility to the administration and to law-abiding society and to let such a group influence the newcomer. How is such a group to be molded? Can psychotherapy, for instance, achieve this goal?

## *Psychotherapeutic Methods*

Traditional individual therapy is essentially a dyadic relationship. As such, it rests on the transference of the patient's affectional feelings and excludes others from this relationship. The incentive to change which comes from the patient's relationship to the therapist is purely individual. Therefore as far as a group is concerned it constitutes a divisive element. It arouses jealousy and antagonism, suspicion and mistrust.

There is considerable evidence in the literature on institutions that the informal social group distrusts and resents individual therapy and that this resentment is in direct proportion to the strength of the group's hostility towards the administration and of the need for social cohesion aroused by its members' defensiveness. The effect of intensive individual psychotherapy is to separate the patient from the informal group, since a motivation stronger than group influence has set in and the identification with the therapist replaces identification with group members and leaders. Such a relatonship seems to be achieved more successfully with individuals whose group loyalty to the informal inmate organization is not particularly strong to begin with, and who, because of specific neurotic problems, have always moved on the fringes of the informal group. With those group members who maintain a very strong loyalty to their informal peer group, individual therapy is very often, though by no means always, ineffective.

In general, individual therapy tends to weaken the informal organization and atomize its membership. Since it cannot be effectively provided to all, partly because it promises no success in some cases, partly for economic reasons, it cannot be expected to change group values.

As limitations of individual therapy have become recognized, group therapy has been called upon to fill in the gaps. However, it too has its limitations.

The beneficial effects of group therapy on withdrawn individuals, some types of alcoholics, and other isolates, have raised expectations for this type of treatment which, in the case of juvenile delinquents, have not as yet been fulfilled. The most important misconception of the applicability of certain forms of group therapy seems to lie in the failure to understand that in the case of many a delinquent the need is neither to foster his integration into his peer group nor to help him overcome a sense of isolation. Indeed, the average individual in a State training school, whatever his personality difficulties, shares a value system and considerable degree of intimacy with like-minded individuals. It is, perhaps, precisely for the sake of this sharing that he has entered into delinquent activity. Therefore, the traditional form of group psychotherapy, which is supposed to effect reorientation of an individual to his society, misses the mark, creates a conflict between the members of the informal social group, and tends to isolate the patient rather than help him integrate into nondelinquent society.

A more hopeful version of the process, called guided group interaction, has been tried out by McCorkle, Bixby, and others.[9] Its aims and mode of attack seem more likely to satisfy the conditions necessary for changing group, and hence individual, values. How effective it can be is not as yet clearly apparent, but very likely with a group of selected individuals, on a very small scale, as in the current Highfields project, it can succeed. At Highfields, an experimental institution in New Jersey, the individuals are there for such a short time that they hardly have time to become strongly attached to an informal group structure. While this experiment may ultimately be of use, the method is not practicable within the framework of most training schools as set up now.

While efforts at both individual and group psychotherapy can be useful within institutions, their effectiveness is limited by the institutional setting and the varieties of individual personalities it includes.

### *Carriers of Change*

Historical and experimental evidence amassed during the past few years points to the potentialities of the social group as an effector of change in values. Evidence from industrial relations, the armed forces, religious sects, and small-group research indicates a way to the development of hypotheses suitable for testing in correctional settings. The following are only a few of the propositions that seem particularly relevant:

1. Changes in the attitudes and values of group members are directly related to the needs that can thereby be fulfilled. Therefore, if recognized needs can be envisaged as better met by a change in group goals or values, the group is likely to change.

2. Such changes are the more effective the more the members have participated in formulating and discussing them.

3. Value changes in organized groups are more effective if the group is definitely task-oriented and if clear-cut communication and understanding exist concerning the goal to be reached and the means whereby it is to be reached.

4. Change in values of group members is positively correlated with a lack of competitiveness and conflict within the group.

5. Change is related to the degree in which each individual sees that his effort is needed for the achievement of the common goal or the maintenance of his standing within the group.

6. Changes of attitudes and values are more likely to occur through group goals set through the group's own motivation rather than imposed from outside the group, and are less likely to occur through goals dictated by an out-group with which the in-group is in conflict.

### *Steps Toward Change*

Among the suggestions for training schools that can be derived from these propositions are the following:

1. Ways might be explored for making the institutional population's informal organization, as well as the individual, more task-oriented. In other words, attempts might be made to discover what other goals, especially group goals, aside from the goal of release from the institution, can be explicitly fostered and achieved by the population of the training school. This is an exceedingly complicated problem but one well deserving of exploration, for the aimlessness of life in many an institution contributes many undesirable features to the informal social organization.

The possibilities of task orientation are not exhausted by industrial work or work in the ordinary sense of the word. These possibilities include well-defined group goals and an array of means to their achievement. General goals enunciated by the administration as, "We are here to learn to live together," or, "We should learn to get along with our fellow man," are not task-oriented in the sense referred to here. Parenthetically, task orientation among adolescent groups in general is a pressing need in present-day society, and if made part of a delinquency prevention program might well have strong beneficial effects.

2. Since the breaking up of informal organization is difficult to achieve, and even when achieved may not be very beneficial because of the resulting individual isolation, means might be explored for lessening the social distance between the administration and the informal social groupings.

If the adolescent in a training school is eventually to live as a part of law-abiding society he must be able to see himself in a role accepted by law-abiding society. The greater the distance between administration and institutional population the less likely are the young people's groups to change in a desirable direction.

The process of reducing social distance between administration and institutional population is not as difficult in respect to adolescents as to adults. Even the delinquent adolescent leans toward accepting the leadership and ascendancy of older persons because he has his dependency needs and because general cultural patterns tend in this direction. For the administration to share experiences with the informal organization and to recognize its position may be one way of lessening social distance.

3. Reward systems might be developed for group rather than individual performance. Group incentive will become easier to stimulate as a more task-oriented group life is developed in institutions. The present system of individual rewards tends to foster isolation and to leave the more antagonistic group members untouched.

4. Use of the existing group leadership to foster change within the group might also be explored. Leaders are generally considered troublesome because the direction in which they assert their leadership more often than not runs counter to the aims of the administration. However, just as informal groups are part and parcel of any large-scale organization, so are informal group leaders. Since they play an important part in maintaining group cohesiveness and fostering group identification they can be key figures in an attempt to utilize the group for effecting change of individual values.

5. Finally, since many group members might be amenable to therapy, informal groups might be made the units of therapy rather than artificially formed groups based on individual selection. While Slavson and others have suggested that the usual type of group therapy is counterindicated for certain types of character disorders,[10] a more directive form, such as guided group interaction, utilizing the informal grouping might be helpful in changing group goals. This could be followed up by a more traditional type of therapy, group or individual, for some persons.

### *In Summary*

It seems, then, that the informal groups which emerge in a training-school population might be made to serve important retraining functions if properly utilized. This suggestion is based on the observations that much delinquent behavior is group behavior and that the social group is a crucial agent in the maintenance or change of the value systems of its constituent members. A better understanding of the group dynamics within a training school may serve to make it a more effective agency in the retraining of juvenile offenders.

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# CHANGE IS THE WAY OF LIFE

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A COMMUNICATIONS officer in Alaska may have been the first to see it after it left the earth—"a spark of warm orange" in the northern sky at dawn—a little mechanical ball spinning around our startled planet, listening for secrets in outer space, beeping these back as it bustled along, putting us on notice that the world as we have known it will never be the same again.

Will the experiences which the Space Age has in store for us be so strange, so different, that we cannot relate them in any logical fashion to familiar values, forms of life, and ways of living? Or do we, perhaps, have a scientific frame of reference which will help us to adjust our feeling and our thinking to this boundlessness with some degree of understanding and control?

The International Geophysical Year is an imaginative attempt to establish such an integrative framework for the physical, biological, and to a certain extent the social sciences. The work now being done in a number of research centers toward a general theory for the behavioral sciences is another approach, from a somewhat different direction. More or less closely related to these major programs are a growing number of smaller projects of an interdisciplinary nature which explore the underlying logical relationships within and between systems of ideas.

An interesting example of such a project is the conference on the meaning of development convened in 1955 by the University of Minnesota. The proceedings of this colloquium have recently been published in the book which is the subject of this review: *The Concept of Development*, edited by Dale B. Harris.[1] Contributors to this volume are scientists, scholars, or practitioners in the behavioral sciences and related professional fields. They were asked "to state the concept [of development] in their own terms and to assess its usefulness to their fields as they saw it."

Development, the first author, the philosopher Ernest Nagel, points out, is a word with protean meanings. Originally a biological term, it has been freely used to describe the changes which take place over time in such different organizations as language, historical movements, societies, the human personality, systems of thought, and bodies of knowledge.

It is therefore important to know to what extent scientists agree upon a definition of it and upon the nature of the processes involved. We must know, further, what types of research are most needed to bridge gaps in our present understanding of these processes; what disciplines or combinations of disciplines should undertake these researches; and how developmental theory can help us to deal more intelligently with change in a world full of unsolved problems.

At the Minnesota conference, it was assumed that development is process, not end product; that development and change are not the same thing; that it is more important to understand what happens in the course of development than to limit the scope of the concept by too precise definition. Certain assumptions were also made with respect to the process itself: That development takes place within systems which have definite structures and definite sets of pre-existing capacities; that it involves the organization of elements or parts within these systems into larger functional units or wholes; that it progresses by means of sequential changes which contribute to the generation of other, describable systems of things, or properties of things; that it takes place over time.

Within this frame of reference, each author deals ably with the topic assigned to him. More than this, each draws from his own field insights and findings which suggest new ways of looking at problems of common concern. It is especially interesting to see what happens in this series of papers to four questions which appear to have intrigued all members of the conference: To what extent does heredity determine development? How much is now known about the dynamics of development? Can the concept be transferred from the biological to the social sciences and still make sense? How can progress in development be evaluated?

### *Determinism and Differentiation*

Ernest Nagel opens the discussion of the first one: Determinism, he believes, "merely expresses in general form that component in the meaning of development which connects the outcome of developmental process with antecedent structure and latent capacity." The intimate nature of these connections is not known, and the question of how to account for the emergence of new traits and new levels of organization in the course of organic development cannot be answered in terms of any one of the major theories so far advanced. But new ways of looking at developmental theory may enable us to understand "the conditions, whatever these may be, under which growth of human personality is possible and under which the scope of moral choice may be enlarged."

There is considerable support in all of these papers for Nagel's position. The educationist in the group, Willard Olson, calls attention to the change in genetic theory from the older concept of single genes bearing corresponding hereditary characters to the polygene with many different factors. Interaction between these multifactorial genes starts in the sperm and in the egg before they ever meet and continues in the cells of the new organism as long as the latter is alive, constantly creating new possibilities for subsequent development.

The geneticist, J. P. Scott, notes that functional differentiation and variability are the two principal concepts of genetics; that as soon as a part becomes functional its further differentiation tends to modify its own activity; that it is habit formation rather than heredity which tends to put behavior in a straitjacket; that heredity only makes more probable the type of behavior which will be fixed by habit formation in any given situation.

How much is really known about the dynamics of development? No one of the authors deals systematically with this second question but all are preoccupied with it in one way or another.

Heinz Werner, a comparative psychologist, looks again at an old controversial issue: continuity vs. discontinuity in development. He sees no reason to suppose that all developmental change must be continuous. "Underlying the increase in differentiation," he writes, "are the forms and processes which undergo two main kinds of changes: (a) quantitative changes which are either gradual or abrupt, and (b) qualitative changes which, by their very nature, are discontinuous. . . . This opens the way for a developmental study of human behavior not only in terms of universal sequence, but also in terms of individual variations, that is, in terms of growth seen as a branching out process of specialization or aberration."

Robert R. Sears, also a psychologist, feels the need for an entirely new approach to the study of developmental change. To replace older classifications which "sliced behavior into meaningless and entirely arbitrary segments," he offers a new system for analyzing behavior, a system which deals with the action of the person as a whole. The new dimensions proposed are: (a) changes in the degree of precision, efficiency, and speed with which manipulative, locomotor, and communicative acts are performed; (b) changes in the complexity of the stimuli which can evoke effective interaction with the environment; (c) changes in the length and complexity of the action sequences a person uses in relating himself to his environment and securing gratification for his desires; (d) changes in the quality and complexity of the environmental events that are the apparent objectives (or incentives) of action.

Sears discusses three "general sources of influence" by which these changes are brought about: learning, physical maturation, and expectancies for action expressed to the individual by others. Each of these, he says, are "whole fields of scientific investigation."

### *Points of Choice*

All guidance rests on the assumption that increasing knowledge of the dynamics of development will lead to the conservation of growth potential. In discussing this point, John E. Anderson speaks of the original fluidity of all young organisms, of their inherent capacity to respond selectively to stimulation from their environments, of the tremendous importance of these selections because of the extent to which each one determines what happens next.

"Once a choice is made," he says, "cumulative and irreversible changes take place which determine the major aspects of subsequent form . . . In his life, the growing individual meets successively many choice points at which decisions between alternatives are made . . ."

The study of these "choice points" offers a rich field for research. Which are the most critical for future personality development? Where do these come in the major developmental sequences? What factors other than chance influence results at moments of decision? Can some or all of them be modified? Under what circumstances? To what extent?

These questions suggest certain implications which were nowhere made explicit in this absorbing book. For human beings, the most powerful factors affecting decisions at "choice points" are unquestionably human relationships. In their study of these, the social scientists are often at a disadvantage. Their traditionally horizontal, cross-sectional approaches may report what is, but seldom show—much less explain—developmental sequences in human interaction. But if developmental theory can be applied to the study of human relations, the way is open for teamwork in which scientists from many different fields can participate.

And why not? If, as these authors maintain, stimulation is essential for all development, then it must be possible to regard the relation between any two or more organisms as a dynamic system of reciprocal stimulation, an evolving system of stimulus-response patterns which grow and change in accordance with the principles of emergent differentiation.

## *Human Relationships*

It is truly exciting to think that some day we may be able to trace the life histories of the basic human relationships, to learn what each can actually contribute to the growth and development of the individual human being, to find out how the potentialities of each can best be realized.

Our present preoccupation with the mother-child relationship illustrates very well the need for such information. Everyone is for mother love. But how much do we really know about it? Where does it come from? When does it begin to grow? How does it grow? What is its role in the total development of mother and child? If a baby loses his mother, who else can help him achieve which of the developmental goals of infancy? early childhood? later childhood? How?

A research design comprehensive enough to provide answers to such questions would be a combination of cross-sectional and longitudinal studies in many different fields. It would bring into meaningful relation contributions as different as Lehrman's analysis of parental feeding behavior in the ring dove, Sears' theoretical analysis of the way in which the young human child establishes his identification with his mother, and Erik Erikson's concept of stages in personality development.[2] It would certainly also include yet-to-be-discovered methods of investigating the beginnings of symbolization in infancy.

## *Scientific Methods*

This application of developmental theory to human relationships leads directly to the third of the questions posed at the beginning of this review: Can the concept of development be transferred from biology, where it originated, to other scientific fiields and still make sense? Several chapters in *The Concept of Development* focus on this point, particularly those contributed by Norman J. DeWitt, Herbert Heaton and Robert F. Spencer for the humanities and the social sciences; by John A. Anderson, Hyman S. Lippman, John C. Kidneigh, and Willard C. Olson for pediatrics, psychiatry, social work, and education.

DeWitt, a linguist, observes that many people today seem to be moving from uncritical faith in the scientific method to awareness that information produced by systematic inquiry may be true but limited. We do figurative thinking, he says, when we use organic concepts outside of the field of biology. It is safer to test their application in child development than in history, for example, because child development is evolutionary, and the evolutionary process makes no firm commitments. Heaton, a historian, illustrates, with delightful humor, some of the pitfalls in application of development theory in his field.

The concern of the anthropologist, according to Spencer, is to explain man's growth and spread throughout the world, his cultures and his institutions; to find a frame of reference which includes both primitive and civilized man. "Cultures do seem to possess energy and vitality and each to undergo its own evolutionary course," he says. "What the development of each has been, what it shares in common with others, what it has derived from others, aid in the understanding of man at large. This is the basis of man's perspective on himself."

But how does man gain this perspective on himself? How can progress in development be estimated, evaluated? This is a question that seems to echo through many of the pages of this book. The problem is, of course, to find methods of appraisal which can cope with the infinite complexity of life at every stage of the growth and development of every living thing. There is, among these scientists, more than a little concern about certain tendencies in regard to tests and measurements today which seem to them unsound: the tendency to confuse "measurement" with "evaluation," the tendency to overestimate the importance of statistical frequencies, the tendency to overemphasize quantification, the tendency to misrepresent the meaning of "norms."

Werner points out that "the same achievement may be reached by operations genetically quite different. An analysis of types of operations rather than measurement merely in terms of accuracy of performance often reveals the truer developmental picture."

Efforts to establish norms for the evaluation of developmental progress have been, on the whole, disappointing. As Werner also points out, individual differences are obscured when developmental-achievement scores of individuals are averaged to secure a composite curve.

John A. Anderson describes the problems pediatricians have had, over the years, in finding sound criteria by which to appraise the health of children. The early normative anatomical data—height-weight charts, etc.—soon proved inadequate. Variations within age groups were often greater than the differences between adjoining age groups.

Longitudinal studies of children from birth to maturity were more helpful. They revealed individual patterns of physical growth. When used as a basis for prediction, however, they also were often misleading. Children seemed to change, sometimes, in their capacity to develop.

Gradually it became clear, Dr. Anderson says, that "reference to one or a few features of the growth and development were inadequate to define the child as a whole." Interest in defining the meaning of the "total child," he points out, has led naturally to a deeper appreciation of individuality, of the importance of evaluating growth and development in terms of the emerging potentialities of each individual child. Competent statistical analysis of these individual longitudinal growth patterns can show likenesses and differences in rate and quality of development, can even produce norms which can be checked by cross-sectional studies.

For scientists, parents, members of the service professions, and the hypothetical man in the street, developmental theory makes wonderful sense. It assumes that change is the way of life. It gives us the concept of change points as choice points, a fact which has tremendous significance for education. It stresses, above everything else, the profound significance of individuality—of the creative potential in the individual human being. It is infinitely reassuring in times of great change because, even in the most difficult situations, there is always the possibility that new elements will emerge which can be constructively used in the ever ongoing process of creative problem-solving. This is the "open-endedness" of life, our basic security for the Space Age or any other.

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**"If administration exists without a mission, it is merely a method for efficiency but without . . . spiritual motivation as to the reasons why it is important that we become efficient."**

*Robert F. Ott, Director, Division of Child Guardianship, Massachusetts State Department of Public Welfare, at the 1957 annual meeting of the Child Care Council of the United Community Services of Metropolitan Boston*

# BOOK NOTES

COUNSELING AND PSYCHOTHERAPY WITH THE MENTALLY RETARDED; a book of readings. Edited by Chalmers L. Stacey and Manfred F. DeMartino. Foreword by Seymour B. Sarason. Free Press, Glencoe, Ill. 1947. 478 pp. $7.50.

About 50 brief papers are included in this book, which is planned as a text for courses on therapy with the retarded as well as a supplement in general courses dealing with psychotherapy.

A section consisting of three papers is devoted to psychoanalytic methods of treatment. Other sections take up group therapy, play therapy, psychodrama, speech therapy, and vocational-occupational-industrial therapy. Eleven papers treat various aspects of counseling parents of retarded children.

The editors expect the book to be useful to a number of types of workers—counselors, therapists, psychologists, psychiatrists, general medical practitioners, pediatricians, social workers, and institutional workers, as well as to parents of the mentally retarded and others interested in the treatment of retardation.

EDUCATING GIFTED CHILDREN. Robert F. DeHaan and Robert J. Havighurst. University of Chicago Press, Chicago 37. 276 pp. $5.

In planning a school program for gifted children in a medium-sized community, the authors, a professor of psychology and a professor of education, suggest that for this purpose children may be considered suitable for such a program if they are in the highest 10 percent of their age group in one or more specified areas—intellectual ability, creative thinking, scientific ability, social leadership, mechanical skills, and talent in the fine arts. Excluded from this program would be the extremely gifted children—the one-tenth of one percent at the top of the group—for whose education a separate chapter suggests methods.

The book describes methods of identifying gifted children and for developing their abilities through such devices as enrichment of the curriculum, special groupings, and acceleration through the school grades. It emphasizes the importance of understanding the child's motivations for learning and of developing his creativity and special talents. In the planning and operating of such a program, the authors note, the local community's interest and support are needed.

WITH ALL DELIBERATE SPEED; segregation-desegregation in southern schools. Edited by Don Shoemaker. Harper and Brothers, New York. 1957. 239 pp. $3.50.

Shortly after the Supreme Court decided the school-segregation cases on May 17, 1954, the Southern Educational Reporting Service undertook to publish "Southern School News" for the purpose of providing interested parties with factual information regarding desegregation efforts in Southern schools. "With All Deliberate Speed" is a summary of the first 3 years of progress, edited by the executive director of SERS and prepared by members of the "Southern School News" staff, a jurist and an educator.

The opening chapter reviews the legal aspects of desegregation: the history of the school segregation cases; subsequent litigation; judicial resistance to the Supreme Court decision; and evasive legislation. The book then presents the conflict within the Southern States, largely between the Citizens Councils and the National Association for the Advancement of Colored People, to determine whether compliance or defiance of the Supreme Court should be the attitude adopted by school authorities. It also discusses disagreement within religious bodies, labor and industry, and the press regarding the proper path to take. Next comes a review of conflicts over desegregation in a number of specific communities.

Several chapters examine development in border States, in cities, and in the Deep South, in an effort to find reasons for dissimilarities in reactions, including the political implications of segregation.

Two chapters contain studies of the process of desegregation in the District of Columbia and in institutions of higher learning in the South. The final section describes the problems of school administrators and board officials in the midst of the conflicts over methods, policies, irreconcilable State legislation and Federal court decisions, academic freedom, and the like.

RADIATION: what it is and how it affects you. Jack Schubert and Ralph E. Lapp. Viking Press, New York. 1957. 314 pp. $3.95.

As part of a detailed explanation of the hazards of radiation, the authors, one a biologist and chemist, the other an atomic physicist, present a chapter on excessive exposures of children to radiation. They point to some of the reasons why radiation exposure is exceptionally hazardous to young, growing persons: (1) Their tissues are generally more responsive to radiation effects than are those of adults; (2) their long life expectancy permits more damage to be caused by long-delayed radiation-induced injury than could be done to an adult by the same amount of radiation; (3) the accumulation of doses to children's reproductive organs increases the chances of passing on hereditary defects to their descendants.

The authors note that overuse of radiation has not decreased since the 1940's, when information on the hazards became widespread, but has actually increased.

A chapter on biological effects of radiation quotes from the reports of the National Academy of Sciences' Committee on Genetic Effects of Atomic Radiation and of the British Research Council to point out the possibilities of hereditary mental and physical defects occurring in future generations as a result of excessive radiation in present-day parents.

PREGNANCY AND BIRTH; a book for expectant parents. Alan F. Guttmacher, Viking Press, New York. 1957. 335 pp. $4.50.

Addressed to laymen, this book discusses conception, pregnancy, delivery, convalescence after confinement, the postpartum examination, and a number of questions in regard to the newborn child.

# HERE AND THERE

## *Biregional Conference on Children and Youth*

The first biregional conference of State planning commissions for children and youth was held in Memphis, Tenn., in mid-November under the joint sponsorship of the Louisiana Youth Commission, the Tennessee Commission on Youth Guidance, and the Children's Bureau. Representatives of the Mississippi, Florida, Alabama, Arkansas, Texas and New Mexico State commissions joined the members and staffs of the Tennessee and Louisiana commissions for a 2-day discussion of mutual problems and of methods found effective in statewide planning for children and youth.

The Chief of the Children's Bureau, Katherine B. Oettinger, set the stage for the discussions by outlining the following criteria for effective planning: inclusion of all groups concerned with the problem; a foundation in current facts; flexibility; democratic procedures; provision for continuous evaluation.

The working sessions considered the following questions which had been submitted by the commissions.

1. What is the best means of rehabilitating a child in the community upon his return from a training school?
2. What programs are needed for mentally retarded children who get into trouble?
3. How can a youth commission effectively follow through on a problem it has identified and studied?
4. To what degree can or should a State planning group coordinate the planning of all services for children and youth?
5. How can a planning group achieve effective youth participation?
6. How can commissions most effectively use public hearings as a technique in studying problems relating to children and youth?

The first question was discussed from the standpoints both of legal responsibility and needed services. Should authority during the period of parole rest with the court which committed the child or the institution which paroled him? These facts were considered relevant: while courts are closer to the community, a wide range in quality of care exists among them; on the other hand, workers attached to the State training school are not accessible for continuing an emergency service in the community, nor can they keep in touch with community developments which influence the parolee's activities. The discussants agreed that while rehabilitation should have taken place by the time the youth is paroled, actually this is rarely the case since adequate psychiatric services are not available in the training schools to carry out the curative process, and few, if any, communities have programs which provide services to the family to prepare for the child's return.

The acknowledged lack of comprehensive services led the group into a discussion of coordinated planning for all services. It was the consensus that every resource must be tapped and that prior to approaching official appropriating bodies organizations reach an agreement among themselves so that their requests reinforce rather than compete with each other.

In discussing methods of achieving effective youth participation in statewide planning, the conferees came to the conclusion that the adults must define what they expect young people to contribute. In most communities, it was pointed out, a formula must still be found for channeling the large amount of youth participation in a wide range of activities into effective participation in State and national planning. Representatives of other commissions told about extensive youth participation in conferences and annual meetings. It was pointed out that the appropriate training ground for such participation is the local community, with opportunities for increasing responsibilities as experience accumulates.

The Tennessee Youth Guidance Commission reported the use of public hearings throughout the State as a means of factfinding on a selected subject and interpreting the Commission's function. Representatives of two other commissions, reporting that their State statutes give them the right to hold public hearings, recommended that formal hearings be reserved for crucial issues and that other purposes be carried out through studies, forums, and informal public meetings.

## *Indian Youth*

Some 200 people met in Washington late in November for a 2-day conference on American Indian Youth, held under the sponsorship of Arrow, Inc., a nonprofit organization of Indians and non-Indians dedicated to helping Indians to improve their conditions. Among them were representatives of 57 tribes and intertribal organizations, including 25 young people of high-school or college age. Also present were a number of resource people from voluntary and Federal agencies, including the Departments of Labor, the Interior, and Health, Education, and Welfare.

A feature of the conference was a panel discussion in which five of the young people, from various tribes, expressed their concern about conditions among youth on the reservations and tried to find solutions. They identified three major problems: (1) juvenile delinquency; (2) excessive drinking; (3) failure to secure higher education. They reported on their difficulties and successes in forming youth organizations or projects within their own tribes after returning from a regional conference on Indian youth held at Fort Thompson, S. Dak., last spring under the auspices of the University of South Dakota.

Five work groups at the Washington conference brought in numerous recommendations. Among them were included: establishment of high-school and college scholarships for Indians by the tribes themselves, the Federal Government, foundations, churches, and labor and industrial groups; formation of tribal committees on Indian youth; encouragement by Federal, State and nongovernmental agencies of Indian youth organizations and efforts to meet the recreational needs of youth on the reservations; the conducting by Arrow and official agencies of research in regard to Indian youth, especially in relation to their recreational needs, the reasons for their low high-school and college enrollment, the social and psychological conditions of their environment, their health, and the resources available to meet their needs.

The conferees recommended that a similar conference be held in 1958.

## *Public Health*

The Food and Drug Administration of the Department of Health, Education, and Welfare and the Federal Trade Commission have both announced their intention to take prompt action if any manufacturers make false and misleading claims that their products are effective in preventing or treating Asian influenza. In the announcement the FDA quoted a statement by the Public Health Service that years of extensive research and laboratory investigation have shown that inoculation with vaccine is the only reliable means of preventing influenza. However, the PHS added, some drug preparations will relieve some of the discomforts of influenza, and these have a proper place in a physician's treatment of the disease.

. . .

Some 160 public-health projects are planned for 1958 by health administrations in the 21 American Republics, to be conducted in collaboration with the Pan American Sanitary Bureau, regional office of the World Health Organization in the Western Hemisphere. WHO has adopted a budget of $3 million to carry on this work, an increase of $600,000 over the 1957 budget. The program will emphasize eradication of malaria, yellow fever, smallpox, and other communicable diseases; strengthening of national health services; chronic diseases; occupational health; food and drug services; and the implications of nuclear energy for public health.

. . .

Twenty-four representatives of health professions, insurance organizations, safety interests, labor, industry, and other users of health statistics have been named by the Surgeon General of the U. S. Public Health Service as members of an advisory committee for the U. S. National Health Survey. The Survey is a continuing program under which the Public Health Service makes surveys and studies to determine the extent of illness and disability in the population and to gather related information. Household interviews with a nationwide sample of the population are now being conducted.

. . .

A Commission on Health Careers was formed recently by the National Health Council to plan ways to meet the need for additional qualified health personnel in the United States.

The commission will add impetus to existing local, regional, and national health career programs; investigate the possibilities of health careers, for older as well as young people; and develop a broad-scale factfinding program on such health-manpower problems as: adequacy of educational facilities and programs for potential health workers; availability of scholarships and loan funds; aptitude testing; salary ranges in health occupations; and ways of utilizing highly trained people most effectively. The commission will also develop a program of public information and interpretation on the need for adequate staffing of services.

## *Nutrition*

Nutrition in pregnancy was the subject of a symposium sponsored by the Council on Foods and Nutrition of the American Medical Association at the University of Missouri Medical Center, Columbia, on October 11. The symposium was sponsored jointly by the university's school of medicine, its adult education and extension service, and the Boone County Medical Society. Several professions were represented among the speakers and panel participants and in the audience, notably physicians and medical students, nurses, biochemists, dietitians, and nutritionists.

The formal papers presented either findings from original research or generalizations based on a review of investigations and practice. Considerable emphasis was placed on the desirability of maintaining good nutritional status in girls throughout the growing period so that they may be ready for the added demands of pregnancy and lactation. It was stressed that many young wives of today have to meet these nutritional demands before they have completed their own growth. There was agreement on the need for additional studies of nutrition in pregnancy and lactation and the desirability of adopting uniform procedures for studies undertaken in many parts of the country, especially in areas of high maternal and perinatal mortality.

## *Vital Statistics*

According to information from the National Office of Vital Statistics, U. S. Department of Health, Education, and Welfare:

In 1955 in the United States 146,504 infants died before, during, or soon after birth. These deaths, called perinatal deaths, included deaths of liveborn infants less than 28 days of age and fetal deaths in pregnancies of 20 or more weeks. The perinatal death rate was 35.6 per 1,000 births (live and still), about the same as the 1954 rate. Among nonwhite infants the rate was 54.1 per 1,000, also about the same as in the previous year.

Among the States the perinatal death rate was lowest in Idaho, Iowa, and Utah—about 28 or 29 per 1,000—and highest, 50.1, in Mississippi. In all the rest of the States the rate was between 30 and 40 percent, except for Alabama, Virginia, Louisiana, South Carolina, Colorado, Georgia, and the District of Columbia. In Puerto Rico and the Virgin Islands the rates were above 60.

In 1955 the average life expectancy of newborn babies was 69.5 years. For those born of white mothers it was 73.6 years for girls and 67.3 for boys; for those born of nonwhite mothers it was 65.9 for girls and 61.2 for boys.

Since the period 1900–02 the average duration of life has increased by 19.1 years for white males, 22.5 for white females, 28.7 for nonwhite males, and 30.9 for nonwhite females.

## *Juvenile Delinquency*

Provisional findings by the Children's Bureau indicate that in 1956 juvenile-court delinquency cases increased in the United States by about 20 percent over the number handled by the courts in 1955. The child population of juvenile-court age (generally 10 through 17) increased only 3 percent for the country. The 1955–1956 increase was more than twice as great as that for 1954–1955, which was 9 percent.

On the basis of the juvenile-court statistics, the Bureau estimates that roughly 2 percent of the 20.6 million children of juvenile-court age in the United States were referred to the courts in delinquency cases in 1956. Many more children than come to the attention of juvenile courts for delinquency perhaps two to three times as many are dealt with by the police for misbehavior without referral to court.

. . .

New York City recently opened a new facility for temporary detention of boys remanded by the courts. The eight-story building, accommodating 315 boys in single rooms, has seven wings and contains a reception center for incoming boys, medical-service areas, examination rooms, nurses' and administration offices, 3 workshops, 16 classrooms, recreation rooms, a library, and a central kitchen and dining rooms. The facility, called Youth House for Boys, replaces the Youth House opened 13 years ago as a part of a program of nonpunitive detention of delinquent boys which provides diagnostic reports to the courts. The program is financed by the city, but a private interfaith board appointed by the mayor administers the funds and sets policy.

## *Adoptions*

Principles regarding the role of a physician in adoption were discussed by 17 physicians from various parts of the country at a 2-day meeting convened by the Children's Bureau late in November.

Included in the group were specialists in obstetrics, pediatrics, psychiatry, and internal medicine, as well as doctors in general practice, public health, and hospital administration.

The time and circumstances around which a child is placed for adoption were stressed as of primary importance and there was general agreement that although the adoption process involves the rights of the natural parents and adoptive parents, the rights of the child are paramount.

The group arrived at the following principles:

The physician has direct responsibilities to the natural parent, the child, and the adoptive couple. He is responsible for arranging adequate obstetrical care for the expectant mother, a diagnostic appraisal and treatment of the child, and adequate fertility assessment and medical evaluation of the prospective adoptive couple. He has direct responsibility for referring unmarried mothers and prospective adoptive couples to authorized social agencies.

A physician also has indirect responsibilities in adoption. He serves as a consultant for social agencies. He helps to develop hospital policies providing medical care and social services for the mother and child and prohibiting independent placements. He carries on research leading to improvement of adoption practices, such as studies in growth and development, genetics, or fertility. He helps to arouse community support for improvement of adoption services and to develop appropriate legislation in regard to adoption practices.

As an educator, the physician fosters understanding of the emotional reactions, motivations, and mental-health implications involved in adoption as he works with professional medical schools, national State and local medical societies, nursing groups, hospital administrators, and public health and welfare administrators. He participates in community-education projects involving councils of social agencies, clergymen, judges, bar associations, legislators, and school administrators.

The Children's Bureau is planning to publish a statement on the role of the physician in adoption as seen in this conference.

## *Human Relations*

As a result of seven regional conferences on "human-relations education," sponsored by the Anti-Defamation League of B'nai B'rith, the League recently formulated a number of recommendations addressed to State departments of education, aimed at bringing about healthier interpersonal relations in public schools. The conferences, which included teachers, school administrators, representatives of agencies fostering improved intergroup relations, and others with special skills, were held in New York, New Jersey, Illinois, California, Pennsylvania, Oklahoma, and Massachusetts.

The League urges State departments of education to give moral support to school workers who are trying to develop significant programs for improved human relations and suggests that the departments, working with concerned agencies, set up procedures for exchanging materials and experiences in this regard.

As a step toward emphasizing good human relations in the classroom, the League recommends examination of the purpose, structure, organization, and curriculum of the public school.

Teacher-training institutions, the League maintains, should emphasize human relations in their programs so as to help students become better qualified to teach.

The strains on human relations presented by community changes should be recognized by State departments of education, the League notes, urging these departments to make help available to communities undergoing changes and to work with local people to relieve tensions.

. . .

A report on the psychological aspects of desegregation formulated by the committee on social issues of the Group for the Advancement of Psychiatry is especially addressed to educators, counselors, social workers, psychologists, and school administrators "in the hope that better understanding will facilitate use of our intellectual and social skills" in solving the problems of adjustment of both races. After identifying the psychological damage to individuals, the community and the country arising from segregation, the report discusses the psychodynamics of prejudice, the stages of attitude change, the effect of group processes on attitudes, and the role of authority and leadership in achieving change.

Recognizing that in a transitional period many children may react to the impact of newness and stress with behavior problems, the report points out that adults, in order to be able to help, must be aware not only of the defense mechanisms at work within the children but also of those within themselves. It also warns against confusing problems arising from other sources, such as lack of proper social and recreational services, with those arising from desegregation. ("Psychiatric Aspects of School Desegregation, Report No. 37." Group for the Advancement of Psychiatry, 1790 Broadway, New York 19. Price $1; less in quantity.)

## *Radiation*

A committee of the World Health Organization recently drew up a plan for training public-health workers of all kinds to protect the public against nuclear radiation. Under the plan courses ranging in length from one day to several weeks are recommended as minimum preparation for meeting their responsibility for such protection. Courses are recommended for such personnel as hospital administrators, industrial-hygiene workers, sanitary and hydraulic engineers, veterinary health officers, mental-health workers, and public-health nurses, as well as for persons studying for public-health careers.

Fundamentally, the committee stated, the approach must be one of prevention through limitation or elimination of exposure, since at the present time there is little or no chance of alleviating the effects of radiation injury.

The committee pointed to the principle that public-health authorities have responsibility for protection of the public from the effects of ionizing radiation and that this responsibility begins with the selection of the site of the reactor and continues through all steps in the use of radioactivity.

. . .

At their annual meeting with the Surgeon General of the Public Health Service and the Chief of the Children's Bureau in Washington late in November, the State and Territorial Health Officers recommended that the Public Health Service develop data on safety in radiological installations and techniques in connection with Federal-State hospital construction and State licensing programs. The Association of State and Territorial Health Officers, meeting at the same time, recommended the formation of a committee to review facts and expert opinions on use of ionizing radiations and to provide advice on this subject for medical and other groups.

. . .

The Public Health Service, in a statement issued by the Surgeon General in mid-November has recommended that mass X-ray surveys for tuberculosis be conducted on a selective rather than a community-wide basis. Recommending that such surveys be continued for high-risk groups, such as persons confined to hospitals or institutions, low-income families, migrant workers, and persons known to have been exposed to radiation, the Service suggests that otherwise community case-finding programs limit the use of chest X-rays to persons reacting positively to tuberculin skin testing. The recommendations were based on the advice of a committee of medical and public health experts called together to consider recent changes in the nature of the tuberculosis problem in this country, the impact of these changes on X-ray screening programs, and the problem of low-level radiation exposure from X-rays.

## *Womanpower*

"Work in the lives of married women" was the theme of a conference sponsored by the National Manpower Council and held at Columbia University's Arden House in late October. "Work," in this case, means paid employment outside the home. The 90 members of the conference were drawn from a number of fields and professions: business, industry, education, labor, religion, social welfare, social science, psychiatry, publications, government.

Using as a springboard the Manpower Council's recent report, "Womanpower," and drawing also on a number of working papers written by conference members, the group spent 4½ days discussing the implications of the widespread and growing employment of married women—a development referred to as a "revolution."

According to "Womanpower," 3 out of every 10 married women are now working. Nearly 2 out of every 5 mothers whose children are of school age are in the labor force, and about 16 percent of those whose children are under 6. A considerable proportion of the working mothers of young children have lost their husbands through death, desertion, divorce, or some other cause.

Three points were stressed repeatedly during the discussions: (1) women are marrying younger and having children younger, so that by the time the last child is out of the home the mother still has many years of active life ahead of her; (2) many women today look forward to a life in which phases of gainful employment alternate with a period of childbearing and homemaking; (3) more women today have more choice than women used to have of whether or not they will work. It was also made clear, however, that many women work because they have no choice.

Many participants expressed the belief that results of maternal employment can be favorable for the family, providing the children have adequate supervision, and the mother is able to maintain a warm, close, consistent relationship with them. To aid in this they recommended that communities provide adequate daytime services for children.

The members saw no causal connection between maternal employment and juvenile delinquency. However, they pointed to the need for tested information about the effects of maternal employment on individual children and on the family.

## *Facts and Figures*

Although the number of active cases of tuberculosis has decreased almost 30 percent since 1952, about 250,000 persons in the United States are estimated to have the disease in its active form, the U. S. Public Health Service and the National Tuberculosis Association reported recently. In addition some 550,000 persons are estimated to have the disease in an inactive form. These estimates are compiled on the basis of a nationwide study carried on jointly by the two organizations. Judging from the number of previously undiscovered cases found in X-ray surveys, the PHS and the Association estimate that almost 40 percent of the active cases are unknown to medical and health authorities and that these persons are not receiving any type of care.

. . .

Under State and Federal programs in 1956 about 225,000 women received maternity medical services at public-health clinics, and 430,000 received maternity nursing services. About 517,000 infants and 617,000 preschool children (ages 1–4) were brought to well-child clinics or cinferences. Nursing service was given to 1,493,000 infants and preschool children, and dental treatments to 354,000 infants and preschool children. More than 11 million children were immunized against poliomyelitis at public-health clinics; over 1,400,000 were immunized against diphtheria and 1,360,000 against smallpox. In addition to the above, more than 5½ million booster shots and revaccinations of all types were given.

. . .

Approximately 296,000 crippled children were treated by doctors in 1956; about 52,000 received 1,373,000 days' hospital care; some 3,800 received 340,000 days' care in convalescent homes. About half the patients had orthopedic handicaps. Among other conditions treated were: rheumatic fever, epilepsy, defective hearing or sight, and cerebral palsy.

# IN THE JOURNALS

## *Trainable Retarded Children*

Only for the past several years have even a few cities and States been accepting severely retarded children in their school systems, though the educable have been accepted for half a century, reports I. Ignacy Goldberg in the December 1957 issue of *Exceptional Children*. ("Some Aspects of the Current Status of Education and Training in the United States for Trainable Mentally Retarded Children.")

The author, who is associate professor of education at Teachers College, Columbia University, and assistant director of its mental-retardation project, presents: a summary of the characteristics of 1,200 trainable children in day and residential schools; figures on the estimated prevalence of severely retarded trainable children, by State, and the numbers in public and private day classes and residential schools: information on State legislative and administrative provisions concerning the education of trainable children; and a formulation of the personal, social, and vocational goals of current educational programs.

The information is based on a review of the literature and on replies from two questionnaires, one sent to selected teachers of retarded children and the other to all State directors of special education in the United States, to superintendents of schools in all cities with 50,000 population or over, and to all units of the National Association for Retarded Children.

## *Regulatory Standards*

Whatever methods are used by health and welfare departments in developing regulatory standards for operating day-care centers and other facilities for care of children or adults, the standards should represent a clearly enforceable minimum which the community is willing to accept, according to Gertrude Binder and Norris E. Class, writing in *Social Casework* for November 1957. ("Regulatory Standards for Welfare Services.")

The standards need to be acceptable also to the group of persons whose work is subject to regulation, say the authors. They further recommend that the standards be: flexible enough to allow the regulating agency to apply them equally to the various facilities without bias or caprice; flexible enough and sufficiently free of unnecessary detail to allow for individual preferences, yet not too brief; and clearly enough written to help a person who wishes to engage in the regulated activity to know what he must do.

## *Working Mothers*

What it means to a teen-age girl to have her mother go out to work was the subject of a teen-agers' meeting described in the December 1957 *YWCA Magazine*. ("Y-Teen Summer Conference.") Heading the discussion was a panel consisting of a teen-age girl whose mother was employed; an employed mother, who had four children; an employer, who was also a father; a minister; and a woman high-school teacher. About 150 teen-age girls, attending a Y-teen conference, made up the participating audience. About half the girls had working mothers.

Panel members and audience agreed that the mother's physical presence in the home does not necessarily provide good family life for teen-agers, as distinguished from younger children. Some of the girls felt that independence and a sense of responsibility sometimes develop sooner in teen-agers when their mother goes out to work. The employer noted that increasing flexibility of store schedules now permits many mothers to work during school hours only. A summary emphasized that no one pattern is best for all.

* * *

Sheldon and Eleanor Glueck, writing in *Mental Hygiene* for July 1957, reexamine the data that they published in their book, "Unraveling Juvenile Delinquency," to find out evidence concerning whether, among the 1,000 boys they studied, the mother's employment had a harmful effect on the child. ("Working Mothers and Delinquency.") Comparing 500 delinquents with an equal number of nondelinquents, the authors found that a similar proportion of mothers of both delinquents and nondelinquents were *regularly* employed, but that a higher proportion of delinquents had mothers who worked *irregularly*.

## *Cutting Waiting Time*

Reporting in *Child Welfare* for November 1957 on trends in adoptive placement in a statewide voluntary nonsectarian agency, the Washington Children's Home Society, Seattle, Elizabeth T. Bannister, the agency's assistant State director, presents figures showing that between 1951 and 1956 the agency's waiting time for families that apply for a child to adopt was cut by more than half. ("Analyzing a Statewide Adoption Agency's Statistics.") During the same period the median age of the infants placed dropped from over 4 months to less than 3 months. The author attributes these changes to changes in the agency's placement policies and in its policy in handling new applicants. These include a self-screening process through orientation meetings for couples inquiring about adoption, and monthly reviews of all newly filed applications followed by notification of each applying couple about whether or not the home study will be continued.

The author also quotes figures from the State public welfare agency showing that between 1950 and 1956 the percentage of independent adoptions by persons unrelated to the child decreased from more than half to less than one-fifth.

## *Programs to Fit the Boys*

A delinquency-prevention program designed for excitable boys might psychologically harm those of an inhibited type, and vice versa, says a clinical psychologist and a sociologist, writing in the *Journal of Criminal Law, Criminology, and Police Science* for July–August 1957. ("Personalities of Predelinquent Boys," by Starke R. Hathaway and Elio D. Monchesi.")

After studying 1,000 boys over a 5-year period, some of whom became delinquent, the authors note some of the relationships between personalities and delinquency. The variations in personality, they find, point to a need for diversified community programs.

# READERS' EXCHANGE

### STUDT: *Indigenous organizations*

Because new developments in delinquency prevention are rare, the recent growth of interest in seeking out and working with hostile and delinquent groups of male adolescents is of more than passing interest. Elliot Studt is to be complimented for her able analysis of the elements of group life useful in understanding the dynamics of the street-corner gang. (See "The Nature of Hard-to-Reach Groups," CHILDREN, November–December 1957.) Workers in this newest of vineyards thirsting for "how-to-do-it" directives will have to wait until the foundations are built through such analyses.

The dimensions of group life discussed by Dr. Studt for the most part seem to correspond to realities widely recognized by those who have worked with delinquent groups. The two likely to be the least amenable to manipulation and, therefore, most neglected in currently organized programs of street-gang work are the group's perception of the community and the community's perception of the group. Such neglect can have only unfortunate consequences since virtually all of the members of the street groups need ultimately to find their way to a stable and orderly life within the very communities which, as adolescents, they attack.

Difficulty in using indigenous adult groups and institutions constructively in work with street gangs stems from the fact that the acquisition of knowledge about such resources and appropriate relationships with those who control them is in itself a task of some magnitude. The training and orientation of the groupworker define the problem group and the worker's relationship to the group as having central importance. Other concerns tend to be treated as peripheral.

Essential in the development of work with street gangs is supplementary training of the group-worker to enable him to cultivate and use the native institutional resources of the local community. In addition, two other patterns may be suggested. Local social agencies may employ part-time non-professional persons as street workers who, being residents of the community in which they work, have access to the institutional forces needed. Or professional group workers may be employed by youth-welfare agencies organized and led by local residents.

*Solomon Kobrin*
*Sociologist, Illinois Institute for Juvenile Research, Chicago*

### DOUVAN: *Trouble with identity*

In reporting on the Michigan studies of adolescents, Elizabeth Douvan concludes that the concepts of adolescent independence and conflict about identity and role apply much more to boys than to girls. (See "Independence and Identity in Adolescence," by Elizabeth Douvan, CHILDREN, September–October 1957.)

It appears to this reader that Dr. Douvan is on more solid ground in the conclusions pertaining to independence than in those that concern identity. We have long observed that adolescent boys as compared with girls conform less to study requirements, act out more at school and home, drop out of school at a greater rate, create more hostile fads and, in general, take more vigorous action in wrenching loose strong ties to family and authority. Dr. Douvan's article affirms these observations.

The question of identity is more complex and cannot be probed adequately with the technique and the kinds of questions used in the Boy Scout and Girl Scout Studies. The studies present very limited data for concluding that "the question of identity is postponed for them" (girls).

The problem of identity for girls not only exists in intensity, but is more difficult to resolve than in the case of boys. True, the girl has to postpone her chief feminine role, marriage. Nevertheless, she is very concerned about whether she will be loved for herself: whether her father will support her feminine development; whether her mother will withdraw support as she shows signs of being a sexual person with concerns about popularity, looks, dating manners, and styles. Though on the surface all looks calm, these are deep concerns about identity.

The University of Michigan Study interviewers could not penetrate into these matters because of the structure of the questioning and because girls do not verbalize readily to a stranger, or to themselves, on such critical subjects. Better evidence of how they feel would be revealed by studies of fatigue and illness, physical complaints to school nurses, autobiographical material gathered over a period of time, and reports of parents regarding temperamental behavior and sensitivity in their daughters.

Moreover, while boys seem to have a more immediately attainable goal in industrial productivity, girls also are concerned about this goal. High-school girls in lower-middle and lower-class families who know that they will not continue much longer in formal schooling show very real concern about a known future involving both marriage *and* work. My studies show that in the tenth grade girls are quite preoccupied about the industrial role they will develop, with the familiar anxiety attending the problem of conflicting choices.

If anything, the problem of acquiring a gratifying identity is more of an issue for postpubescent girls than boys because of the multiple roles they must learn for the complex style of femininity in our culture. Possibly this is why they give more to their school studies than do boys. Doing well in school may afford an acceptable self-image and relief from other decisions.

With respect to identity, both boys and girls in junior and senior high school are involved and concerned. Each presents a distinctive problem. In their search the boys seem to act out a lot of the problem; the girls worry it out internally, turn some of it into somatic complaints and—a definite clue to concern about identity—become more dependent on mothers and teachers.

*Donald McNassor*
*Professor of Education, Claremont Graduate School, Claremont, Calif.*

## SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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SERVICES IN PUBLIC ASSISTANCE. The Role of The Caseworker. Helen B. Foster. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance. PA Report No. 30. 34 pp. 20 cents.

Planned to help staffs of agencies administering public assistance, this guide explains the nature of the public-assistance caseworker's job and examines its two major components—the method used in helping people and the focus of helping them in relation to specific aspects of their needs. It is based on the assumption that "service" should be inherent in every contact of the caseworker with applicants for or recipients of public assistance and should not be regarded merely as an "extra" performed only in relation to selected problem cases.

FOSTER CARE 1956. Seth Low. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. Child Welfare Reports No. 8. 1957. 26 pp. Single copies available from the Bureau without charge.

Based on questionnaires answered by the State public welfare agency in all but two States, this report notes that practically all the States have children who need foster care but are not receiving it because no facilities are available and other children who are receiving foster care but need a different type of such care. The groups most frequently mentioned as including many children needing foster-care facilities and services are: the emotionally disturbed, older children, the mentally retarded, children of minority groups, those with behavior problems, and the physically handicapped.

STATISTICAL REPORTING OF PROBATION SERVICES IN JUVENILE COURTS. Robert L. Rowland and I. Richard Perlman. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1957. 10 pp. Single copies from the Bureau without charge.

This report of a workshop held by the Children's Bureau to help stimulate and improve State and local reporting of probation services lists suggestions the group made to the Bureau. These concern nationwide inventorying of court services and facilities; improving collection of basic national juvenile-court statistics; developing standardized local reporting of probation services; periodically collecting court data such as qualifications of staff; experimenting to develop methods for special types of studies such as time studies; working to get wider coverage in the reporting of juvenile-delinquency research projects; and providing consultation to State and local agencies planning research in delinquency.

THE PUBLIC HEALTH NURSE IN COMMUNITY PLANNING FOR THE MENTALLY RETARDED; address given at the Association of State and Territorial Public Health Nursing Directors Meeting, Washington, D. C., April 2, 1957. Rudolph P. Hormuth. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1957. 13 pp. Single copies available from the Bureau without charge.

Explains how public-health nurses can contribute to diagnostic and treatment programs for mentally retarded infants and older children. The author urges that the doctor planning to help the parents of a retarded child be assisted by "at a minimum" a clinical psychologist, a social worker, and a public-health-nursing consultant.

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What is her future?

Centuries before Columbus this little girl's ancestors came to America, though when and from whence are questions shrouded in mystery. One of some 200,000 American Indian children who live on reservations or in off-reservation Federal boarding schools, she faces problems which raise serious questions as to her future. What these are, why they exist, and some steps being taken to meet them are described in the article which begins on page 55.

## ◄ *the authors*

A native of San Francisco, Phyllis Dunne has spent her entire social-worker career in private agencies there since her graduation from the School of Social Service Administration, University of Chicago. These have included the child-guidance clinic at the Stanford University Hospital, the Family Service Agency and the Native Sons and Daughters Adoption Committee. She has been with Catholic Social Service since 1950.

Educated at the Universities of Copenhagen and Aarhus, Danish psychiatrist Erik Strömgren has taught medical students and directed the program of a state mental hospital since 1945. His belief that genetic and psychiatric theories of mental disturbances are complementary rather than incompatible stems from studies of the genetic factors and epidemiology of mental illness which he has carried on simultaneously with work in the treatment of mentally ill and emotionally disturbed children.

Onetime child-welfare consultant for the Children's Bureau on the West Coast, Aleta Brownlee has spent 5 years in Jugoslavia and Austria as child-welfare consultant to UNRRA and its successor, IRO, and—so far—6 years focusing on the welfare of American Indian children, a task that has taken her to places as remote as Kwigillintok, Alaska. Trained in social work at the University of Chicago, she was a county welfare director and assistant State relief administrator in California before turning her full attention to child welfare.

In addition to the responsibilities she carries for the Citizens' Committee for Children, Marion Rosenwald Ascoli is president of the Northside Center for Child Development, a child-guidance agency in Harlem. She began her volunteer activities in Chicago, where she participated in the establishment of a nursery school and served on the board of the Institute for Psychoanalysis. Since moving to New York she has focused her interests on child guidance services, and has served on the boards of the Jewish Board of Guardians and the Brooklyn Juvenile Guidance Center.

Before joining the faculty of the New York School of Social Work in the fall of 1956, Lloyd E. Ohlin was director of the University of Chicago's center for education and research in corrections and consultant on research to the sheriff of Cook County and to the American Bar Foundation. For the previous 6 years he was on the staff of the Illinois Parole and Pardon Board, first as sociologist-actuary at Joliet Penitentiary and later as supervising research sociologist in the Chicago office. In 1953 he spent 3 months in Korea studying prisoner-of-war camps.

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*How one social agency is focusing major effort and skill on . . .*

# PLACING CHILDREN OF MINORITY GROUPS FOR ADOPTION

PHYLLIS DUNNE, M. S. S. A.
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SOCIAL AGENCIES responsible for the care of children continue to struggle with a combination of factors which sometimes seem almost irreconcilable. On the one hand, certain parts of the public are convinced that there are enough "fair-haired" infants for all who desire them, and that agencies are keeping these children from adoption. Agency statements that not enough healthy white infants are available for adoption to meet the demand seem to fall on deaf ears. On the other hand, the agencies are clamoring for adoptive parents for children who are not in great demand but who are in dire need of permanent homes. These are the children known as "hard-to-place" or "with special needs," or "physically handicapped," or "older," or of "minority or mixed minority racial and nationality backgrounds." Here again the agencies' announcements—this time to stimulate applications for children—often seem to be lost on a public which is at least partially hard of hearing. Thus while hopeful couples are pursuing agencies for children they want, and *think* the agency has, agencies have to search diligently for good permanent homes for children they *do* have under care in boarding homes and institutions.

Some social-work statistics indicate that more children who do not fall into the category of the much-sought-after white infant are being adopted today than a few years back. However, ratio of need to availability of homes is still unfavorably disproportionate for such children.

### *In Pursuit of Parents*

Among the agencies engaged in the pursuit of adoptive parents for children who are hard to place is Catholic Social Service of San Francisco, a multiple-service family and child-welfare agency. Since the beginning of its adoption program in the latter part of 1953, this agency has placed a total of 112 children considered hard to place. These included 57 children from infancy to 11 years of age of "minority or mixed racial and nationality background," and 55 children of Caucasian race ranging in age from 2 to 12 years. The minority groups represented among the 57 children included the following: Mexican, Latin American (parental origin in South America), Negro, Filipino, Chinese, Korean, Japanese, American Indian, and various combinations of these groups including partial Caucasian descent. This list has not been based on a scientific anthropological classification of the children according to race or nationality, but on information gained from the children's relatives, court records, and observable appearance, and in some instances by consultation with geneticists.

In placing children of these various backgrounds, the agency has had to sharpen its awareness of variations in cultural attitudes and traditions, and to take these into account in the application of both its home finding and placement procedures.

The children for whom Catholic Social Service established its new program in 1953 were living in boarding homes in the Bay Area of San Francisco, under the direct care of the agency. They were of Roman Catholic religion or parentage and adoptive parents of the same religion were being sought for them.

Like most social agencies, Catholic Social Service has had to limit its program in accordance with shortages of staff and financial resources. In principle, the agency preferred to establish an adoption program for all children under care who needed the service. Faced with inability to provide such a program it decided to gear its efforts to "top priority" need—adoption of the hard-to-place children already under its care.

### *Some Questions*

Despite the difficulties in undertaking this new program, the agency began with a number of major advantages: (1) Motivation to do something definite about a community need; (2) a sincerely interested, hard-working advisory committee, which included, among others, representatives of minority racial groups and specialists in the fields of law, medicine. and business; (3) a determined, hard-working staff with conviction that the job could be done; and (4) good cooperative relationships with other private and public agencies in the area.

In establishing the new program, the agency's board and staff sought to answer the following questions: (1) Where are the adoptive parents for hard-to-place children, particularly those of minority racial and nationality groups, to be found? (2) How are these people to be reached? (3) How do the various minority groups perceive adoption and agency adoption services? (4) Will modifications have to be made in usual adoption-agency procedure, policies, and casework approach in the study process?

While the agency cannot as yet offer conclusive answers to any of these questions, it has had enough experience in the program for the past 4 years to be able to submit some pertinent observations.

### *Where can adoptive parents be found?*

San Francisco's Bay Area includes urban, suburban, and semirural communities, within which are various neighborhoods where certain racial or nationality groups have tended to concentrate. A variety of problems were encountered in finding homes for children of minority groups where they could receive love and also respect for their particular racial heritage. For the child of a single racial background the problem was frequently an insufficient number of applicants of his own race. The question then arose: Can this child be adopted by a couple of a different race?

Experience in boarding-home care in the Bay Area has demonstrated that although some couples have accepted children of a totally different race than their own, in such cases the couple's relatives and neighbors, and even the larger community, tended to reject not only the child but frequently the couple themselves. Moreover, applications to adopt children of a totally different race than the applicants' are extremely rare. None has been received by Catholic Social Service. For these reasons, our agency has not "crossed" full racial lines to date in the placement of children for adoption. The situation may be different in other areas of the country, and attitudes in the Bay Area may eventually change.

The child of mixed racial background presents other problems in adoption in addition to availability of applicants. One of the major questions is: "With which racial group will this child be happiest?" This confronts the adoption agency with the problem of predictability of the young child's future appearance in regard to which race he is most likely to resemble physically. Said one Chinese applicant: "The reason that the Chinese usually want a full Chinese child is because a mixed racial background is recognizable to us. Even if the adopting parents are able to accept the child, families and friends would not usually do so, and the child would suffer as a result." This same attitude and the same difficulties are expressed by people of other races.

The Catholic Social Service has not adhered to the principle of any precise formula of fractional racial-nationality "matching" or coloring. For instance, it did not seek Mexican-German adoptive parents for a child of Mexican-German background, or a couple in which one parent was Negro and the other Caucasian for a child of such racial origin.

Presented with a wide variety in the types of homes needed, the agency has concentrated upon finding: (1) A sufficient number of parents of particular racial groups for children of the same race; and (2) parents who, regardless of their own particular racial heritages, can provide homes in families, neighborhoods, and communities where children of mixed racial backgrounds can be accepted and respected. Although there is still an insufficient number of each, both types of homes have been found during the past 4 years. One Caucasian couple has taken three unrelated children for adoption, each child representing different mixed racial backgrounds.

### *How are applicants to be reached?*

While the agency has sought applicants throughout the total Bay Area, it naturally has concentrated its efforts in neighborhoods or towns or semirural communities where prospective applicants might be living. More homes have been obtained in the smaller communities than in the city of San Francisco.

Initially, the agency used articles in the general press, district and neighborhood papers, the Catholic archdiocesan newspaper, and periodicals and papers having their major circulation among racial and nationality groups. It also got in touch directly with organizations of nationality and racial groups. Whenever an invitation had been received or could be elicited for an agency representative to speak at meetings, either a member of the program's advisory committee or a member of the agency staff used the opportunity to interpret the need. Radio, particularly one Spanish-speaking station, was used in many instances, and television was used when the occasional opportunity became available. Letters were written and telephone and personal calls were made to various organizations, to parish priests, particularly in the parishes where the minority groups lived, and to leaders in certain professions and occupations, such as Negro and Oriental physicians, dentists, lawyers, and presidents and chairmen of national clubs and associations. Latin American organizations and some Catholic club groups, such as the Knights of Peter Claver, were especially helpful.

A small brochure emphasizing the need of homes for Catholic Latin American, Negro, and Filipino children, ages 1 to 10, with people of their own culture and religion, was distributed widely to appropriate groups, while a placard, carrying a similar message, was put on display in busses and bus depots. Placards in combination with brochures which could be taken home by members of the congregation were left in the back of many parish churches.

The agency also got in touch with consulates of a number of countries. This step was taken to reach applicants or their relatives who were closely identified with their country of origin. For example, the mother of a young Filipino woman was strongly opposed to her daughter's wish to adopt a child because adoption is not common in the Philippine Islands. When interpretation of adoption in the United States and the need for homes for Filipino children was given at a meeting by a national representative from the Philippine Islands, this mother became reconciled and even enthusiastic about her daughter and son-in-law becoming adoptive parents.

All of these methods were tried in seeking the first applicants.

As adoptive placements have been made, some response has come, as is usual in boarding-home recruitment, from adoptive parents themselves. Persons whom adoptive applicants have named as references sometimes become enthusiastic about the program and suggest that other friends apply. This has occurred when a full interpretation of the agency

Four different racial heritages are represented in this family. The three children, all adopted through Catholic Social Service of San Francisco, have different racial background from each other and from their adoptive parents.

program has been presented by the worker to the reference in an interview during the study process.

The agency has used personalized individual letters rather than form letters in replying to written inquiries.

The agency's most recent activity is to hold small group meetings of adoptive parents *after adoption is completed.* The purposes of these meetings are· (1) To secure firsthand information from the parents about any factors troublesome to them in applying to our agency, the study process, the placement process, and legal adoption; (2) to learn about apprehensions and interferences among their friends in applying for children; (3) to enlist the assistance of these new parents, on a voluntary basis, in recruiting more homes for children.

With the secure feeling that they already know their child well and that he legally belongs to them, these adoptive parents offer ideas and talk freely about what they have found to be difficult experiences in the adoption process. Some have spoken before groups with which they are closely associated, some have held informal gatherings in their own homes, and a few have given talks to other groups known to the agency. In addition to helping with recruitment, these post-adoption contacts with adoptive parents have given the agency a better perspective for examining and modifying some of its procedures and policies in working with people of minority groups.

### *How do people in "minority groups" perceive adoption?*

On the whole, each group perceives "adoption" differently. This is also true of their perception of agency adoption services. The only common factor that emerges is that generally they have more apprehension, insecurity, and misinformation about social agency adoption services than the native Caucasian population, the majority group in this country.

Our experience has shown that Orientals generally perceive adoption differently than Negroes who, in turn, perceive it in quite a different way than Filipinos or Mexicans or persons of any other minority group.

Adoption is not new in the Chinese culture, but agency adoptions are new and infrequent.

We have been told by Mexican applicants that adoption is not part of their tradition and that adoption through an agency is even less so. "It has always been a tradition of the Mexican people to take relatives' children and other children, and 'absorb' them like one of the family, but adoption is new," they say.

The *individual members* of any particular minority group perceive adoption and adoption agencies on the same basis as every person, regardless of race, perceives anything—according to culture, religion, mores, place of origin, total life experience, and human relationships. Persons of the second-born generation of Orientals in America are more apt to accept adoption agencies than their parents and to perceive them differently. The Negro who has always lived in the Bay Area may apply for a child in response to publicity, but Negroes from rural areas in Southern States have usually come to the agency only if they have friends who have already received a child.

The Mexican born in some valley town in California also perceives adoption and social agencies in a different way than the Mexican born in the more urban San Francisco Bay Area. One Mexican applicant from a valley town told the intake worker: "I walked around the block three times before I could come in. So many of my people were migrant laborers in the valley, and I cannot write English, so I was afraid you would not want me. My wife could not convince me that good parents were the most important thing to you."

We learned very quickly in our experience that assumptions about the members of any race are dangerous. We also learned that our advisory committee and our staff would have to perceive areas of understanding and misunderstanding. We had to gear our efforts in recruiting homes to the *broad cultural implications for each group* in the Bay Area, and our study process *to each applicant on an individual basis.*

We learned to accept the voluble applicant's expression of initial hostility about "red tape," arising from fears that he will not receive a child; to reassure the applicant who has multiple questions based on misinformation, current among all racial groups, about adoption agencies; to extend skillful and carefully timed encouragement to the outwardly passive applicant whose cultural background makes him reticent to discuss personal matters. Each applicant, we found, required of the social worker the kind of sharpened cultural awareness described by Katherine Handley: "She needs not only to be aware of her own reactions to the cultural factors involved, and to assume responsibility for them on a professional level, but she must also be aware of the client's response to whatever feelings they ascribe to her as a person of another culture."[1]

### *Will modifications in process be needed?*

Our agency receives many inquiries from other agencies in regard to the policies we follow in studying the suitability of couples to be the adoptive parents of hard-to-place children. The most frequent questions relate to our requirements on age of applicants, other children in their families, housing, economic status, health, religion, and fee charging.

These policies derive from the conviction that "basically secure" adoptive parents can give love and care to another child if their desire for one is soundly motivated, whether or not they already have one or more natural or adopted children. We consider the applicants' ages in relation to age of the child they desire, and the ages of other children in their family, if there are any. We believe in placing young children with young parents, and older children with parents still young enough to provide them a life with "parents" rather than "grandparents."

We adhere to the usual standards of approval of the applicants' health by licensed physicians, of their religious practices by their parish priest, of their housing by our own home finders. This last must be safe and provide sufficient space for family living, with separate bedrooms for children of different sexes. We look at employment stability and family living standards in relation to financial ability to care for a child or children, but we do not require ownership of property.

Like all other adoption agencies in California, except one, we charge service fees which are adjusted or waived according to economic status.

Throughout our experience we have consciously attempted to avoid letting our need for homes obscure in any way our vision of what future life might be for any child in a particular home. We have also tried to remain acutely aware that adoptive applicants are clients of an agency and not just resources for children.

We have endeavored to be flexible but cautious in adhering to the principles upon which policies were established. Our expectations and standards for qualities of parenthood have not changed but we have made adaptations in some procedures. For instance, in response to inquiries from prospective applicants, we originally sent out a form termed a "preliminary application" and if this was not returned by the applicants we construed this as failure of interest or withdrawal. We placed great significance upon the lateness of response or failure to appear for an intake appointment. We pondered about some people who were loath to agree readily to a home visit after an intake interview.

We soon found that while attitudes are always significant, and the items mentioned worthy of consideration, symptoms of withdrawal or indifference or laxity have to be evaluated according to the sensitivity, tempo and mode of living, and understanding of the applicants involved. On the whole, Caucasians in the Bay Area are more likely than persons of other races to adhere to formalities about appointments and forms, as do some people in all racial groups. Many members of some of the minority groups are afraid of revealing themselves at first, particularly in writing or in filling out forms. In certain occupations and in certain modes of living promptness at appointments is not important. Hesitancy about agreeing to an appointment for a home visit may come from the applicant's self-consciousness about the exterior appearance of his home, rented in the only neighborhood open to his particular racial group.

We were told in a recent meeting with some Negro adoptive parents that they are considered "rich" by friends and neighbors because they have adopted a child, although they and we know they are in modest circumstances. We were also told of an economic block which hinders many Negroes from approaching an adoption agency. Their apprehension stems not only from the usual misconception that agencies expect people to own their homes, but also from the expected cost of medical examinations, attorneys' fees, and exaggerated ideas about agency fees. This meeting demonstrated the need for more detailed interpretation to all kinds of people of what is involved in adoption.

There has been no need to modify the casework approach, for this, of course, continues to mean adaptation of understanding and techniques to the individual. Skill, discernment, and freedom from cultural bias are top priority qualifications in the worker who must evaluate the behavior and emotional reactions of applicants of various races and cultures during the study process. The Caucasian applicant who laughs or cries without much provocation might be diagnosed as neurotic by a fellow Caucasian, but the same response in persons of other cultures where there is no shame in readily revealing joy or sadness may be natural and not neurotic.

We have had to remain aware of the differences in family relationships in various cultures. The Caucasian couple who brings the husband's mother to the intake interview may raise some questions in the worker's mind: Is this man so dependent upon his mother? What is the marital relationship here? However, some cultures still fully accept the matriarch, who is loved and respected. If such an important figure exists in a family being considered as a permanent one for a child, it is important that she as the grandmother-to-be understands what is going on and is included in the study. Although the degrees to which such special cultural characteristics exist vary within and among the different cultural groups, diagnosis should be in line with the appropriate cultural setting.

Noticeable similarities exist in various racial groups' attitudes in regard to children. We have not encountered prejudice among any group against adopting children born out of wedlock. In all groups hesitancy in accepting the physically handicapped child seems to relate to the economic burden of providing for the child's future care rather than to bias against the child. All groups show a preference for the "cuddly baby" or toddler over school-age children. In our experience Caucasian families have shown a greater willingness than others to adopt groups of brothers and sisters. We believe that this stems from the fact that Caucasians generally are in better economic circumstances than others in this area and have had a longer experience in agency adoptions.

### *Other Efforts*

The following developments have been initiated in California since Catholic Social Service started its program in 1953, and they are still going on:

1. "March" (Minority Adoption Recruitment of Children's Homes) was established and started its work in January 1956, with funds provided by the Columbia Foundation, as a coordinating body in recruitment of homes for children of minority groups for all the adoption agencies in the area.

2. Under the sponsorship of the State Department of Social Welfare, a committee composed of representatives of the supervisory staffs of five licensed county adoption agencies and two private agencies has been meeting regularly to exchange information about specific children for whom they need homes and about applicants seeking a child.

3. In January 1957 Adoption Resource Referral Center, known as ARRC, was established by the State Department of Social Welfare to provide opportunity for registration on a statewide basis of available, approved adoptive applicants and of children in need of homes. Registration is done by licensed adoption agencies with safeguards about confidentiality.

In view of this concerted action and our own agency's continued efforts, we at Catholic Social Service of San Francisco look forward to more children having a chance to benefit from family life in permanent homes. We also look forward to further understanding on the part of the general public concerning adoption agencies, as well as to whatever modifications are needed in agency adoption practices to improve services without disturbing the principles fundamental to child welfare.

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[1] Handley, Katherine Newkirk: Social casework and intercultural problems. Journal of Social Casework, February 1947.

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Children . . .

You may give them your love but not your thoughts,
For they have their own thoughts.
You may house their bodies but not their souls,
For their souls dwell in the house of tomorrow, which you cannot visit,
not even in your dreams.
You may strive to be like them, but seek not to make them like you.
For life goes not backward nor tarries with yesterday.

*Kalil Gilbran in* The Prophet

*Is mental illness caused by heredity or environment? A psychiatrist presents some current theories on . . .*

# GENETICS AND MENTAL HEALTH

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THE GOAL of mental-health work is both to cure and to prevent mental disorders insofar as possible. Achievement can only be reached through knowledge of the causes of mental disability and of the relative importance in them of the interacting factors of nature and nurture.

Both factors need close study, including the application of genetical methods. Because these methods are complicated, psychiatric genetics has become a specialty within the field of psychiatric research.

Many psychiatrists are apt to regard genetics with a jaundiced eye. Between the two World Wars some authoritarian countries, for political reasons, stressed the genetical viewpoint to a degree which was without any rational basis. This connection between genetics and politics caused an immediate reaction, not only against *misuse* of human genetics, but unfortunately also against genetics as such.

Another reason for a negative attitude toward genetics is the misconception that if a disease is genetically determined, it must therefore be incurable. People who are interested in genetics are thought not to be interested in therapy. This is both theoretically and practically nonsense.

What is meant then by the statement that, a disease is "purely hereditary"? It means only that when some specific genes are present in an individual then the disorder will manifest itself in all environments which we know about for the present. Today the penetrance of these genes is 100 percent, but this does not mean that the penetrance might not be lowered at some future time. Perhaps some prophylactic measures will be devised which can reduce the risk of certain genes becoming manifest. In some of the remaining cases, therapy will be able only to modify the disease.

The management of diabetes presents an example of such modification. Therapy cannot prevent the genes from manifesting themselves in the form of diabetes, but it can indeed change the lives of diabetics.

In psychiatry we have analogous, if not such striking, examples. The fate of manic-depressives has changed considerably during the past 2 decades of active therapy. The duration of their attacks has decreased by more than 50 percent, and their mortality rate has gone down. We know that some genes are of importance in the development of the manic-depressive syndrome, but we combat their effects.

Even in regard to schizophrenia much progress has been made. Insulin therapy, chlorpromazine and other drugs, along with intensive psychotherapy, have strikingly influenced many cases. It is questionable whether any of these therapies has been able to induce complete cure in any case of schizophrenia, but there is no theoretical reason why cure should not be possible. The genes would still be present but would lose their importance.

Genetics and psychotherapy are not incompatible. Ernst Kretschmer, who has written widely on the importance of constitution in psychiatry, uses psycho-

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**Based on a paper presented at the 1957 annual meeting of the World Federation of Mental Health, Copenhagen.**

therapy extensively and systematically in his clinics in Germany. Eugen Bleuler, while convinced that schizophrenia is largely determined by genetical factors, has presented a penetrating and extensive study of the psychological factors involved. Manfred Bleuler, who has made a series of brilliant studies of the genetics of schizophrenia, is head of a clinic which uses intensive psychotherapy with schizophrenics.

In some respects human genetics do not present the same possibilities as the genetics of other living beings. We cannot experiment on humans. On the other hand, psychiatric genetics offers certain exceptionally good possibilities. Often we can get information from written sources on the mental characteristics of people who have lived generations ago.

There are two kinds of methods used in psychiatric genetics. We seek to know: first, *What* is inherited? secondly, *in which way* is it inherited? The first question is answered by means of the twin method, and the second by genealogical studies.

### *The Study of Twins*

The twin method enables us to calculate directly the importance of genetic factors. But it has some weak points:

**1.** If we compare monovular twins with binovular twins, we must remember that the environment may be more similar for the monovular twins than for the binovular. The environment will tend to treat identical twins in an identical way whereas the obvious differences between nonidentical twins will release different reactions from it.

Thus, similarities between identical twins may to a certain degree be caused by their similar environment. For this reason differences between identical twins are far more interesting than their similarities for they can only be caused by environment, and their existence is a proof of the effect of environmental factors. Studies of identical twins who have lived in different environments are of great importance.

**2.** Conceivably the very fact of being a twin could provoke certain mental characteristics. If this is the case, the trait in question must appear more frequently in twins than in the general population.

**3.** Many of the twin studies which have been published have not been based on representative samples. There has been an understandable tendency to publish accounts of concordant cases while discordant cases have been overlooked as less interesting, thus leading to an overestimation of hereditary factors. Fortunately, during recent decades representative samples have been selected in a number of twin investigations.

### *Genealogical Methods*

Genealogical methods provide a way of attempting to follow certain traits from generation to generation and calculating the incidence of the traits in each generation. In the beginning of the Mendelian era an accumulation of cases of a trait in a family was sometimes taken as a proof of the hereditary character of the trait. This conclusion is, of course, not valid.

People who belong to the same family will naturally very often share the same environment. Therefore the similarities between them could to a certain degree depend on environmental influences. But if many members of the family have exhibited the trait in question even though they have grown up in different environments, the scale turns somewhat in favor of the genetical hypothesis.

These factors need to be investigated closely. Admittedly, geneticists have not always been sufficiently careful in this respect.

In the beginning of the Mendelian era geneticists naturally focussed on diseases which seemed to be inherited in a clear Mendelian way. There are many different psychiatric diseases of this kind but they all are very rare.

Later, geneticists spent a great deal of time attempting to demonstrate Mendelian factors as a basis for the more frequent psychiatric disorders. Schizophrenia especially was studied, but soon it became clear that a simple genetical pattern for this disease would not be found. From a theoretical viewpoint this was disappointing, but practically it did not mean much.

One of the advantages of knowing the mode of inheritance for a specific disease is that this enables us to predict the chances that relatives of a person with the disease will also have it. However, such a prediction can also be made without knowing the mode of inheritance—simply by counting the occurrences of the disease in the different generations within the family. If these calculations are made on a large number of families, the "morbidity risks" or expectancies can be estimated with a fairly high degree of probability. This, however, involves several problems. If through study of a large group of families known to have at least one case of the disease the expectancy for relatives is found to be 50 percent, there is, of course, not the slightest doubt that this "risk" is higher than it is in the general population. But if for some frequent disease—for example, schizophrenia—we find that in a large study group the risk for relatives is only 3 or 4 percent, we may feel that this is more than the risk in the average population, but we do not know it for certain. In order to be certain, we have to determine the expectancy of schizophrenia in the general population.

Different methods can be used for this purpose. Theoretically adequate, but very laborious, is the proband method. To find out whether a certain percentage of schizophrenics among the siblings of schizophrenic probands (originally discovered cases) is higher than in the general population, a geneticist counts the number of schizophrenics among the siblings of some "controls" who have been selected in such a way that they are representative of the general population.

There are other methods, most of them, however, rather doubtful from a statistical point of view. Often statistics of admissions to hospital have been used as a measure of the incidence of certain diseases. This is of course not justifiable as only a fraction of the sick people come to a hospital, and this fraction varies in different populations and from time to time.

### *Making a Census*

It seems more valid to try to count the number of sick people in the general population; in brief, to make a *census*. This method, while much better, is still very unreliable, because the result will depend on the age distribution of the population. Therefore, if different populations are to be compared, a correction for differences in age distribution must be made. This procedure is feasible in many civilized countries, but quite impracticable among primitive populations, where many people do not know how old they are. Moreover, in all countries the higher than average mortality rates of sick or abnormal people throws the incidence figures out of balance.

Even people with mental abnormalities which are not mere symptoms of physical disease have a higher mortality rate than the general population of the same age group. Therefore, if a census is made on the living population, people who have exhibited mental abnormality will be underrepresented in the census. Efforts to make a statistical correction for this are hampered by the continuously changing mortality rate among the mentally ill, which in many countries has steadily decreased since the advent of antibiotics and psychiatric treatment.

This whole subject of psychiatric epidemiology has become a field of mutual interest for geneticists and environmentalists. The realization of how difficult the whole matter is seems to have effected an interprofessional humility. Anthropologists recognize that their intensive studies on small population groups have mainly a qualitative value, while statisticians are grateful for the stimuli which these studies provide.

### *Mental Deficiency*

The phenomenon of mental deficiency includes all kinds of interaction between genetical and environmental factors. A number of specific types of this disorder exist which have a gene as the recognized etiological basis. But the majority of cases cannot be attributed to the action of single specific genes. In about 20 percent the intellectual defect seems to be a sequel of exogenous damage to the brain in utero or during the first years of life. In the remainder, hereditary factors seem to be mainly responsible, but not through single specific genes. These cases seem to represent simple minus-variants with regard to intelligence—the lower points on a Gaussian curve representing the normal intelligence levels of the entire population. Experience in mental testing of large samples of the population seems to support this supposition.

This "normal" variation does not include the definitely pathological cases. The existence of such cases—which are both hereditary and exogenous in origin—accounts for the fact that the distribution of I. Q. levels in the total population is not quite symmetrical, as it should be in a Gaussian curve, but contains too many individuals with intelligence quotients of less than 40–50.

What about the environmental influences of a psychological nature? There is no doubt that the intelligence level—or at least the intelligence quotient—may to some degree be influenced by environmental factors. Variations of up to 20 points do occur in the I. Q.'s of some individuals, but they seem to be extremely rare. The great majority of variations are no greater than 5 points.

In regard to the interaction of intelligence and social influences there are some basic problems which can never be solved. When we are talking of intelligence, do we mean some kind of sum of a number of measurable faculties, or do we mean some mysterious thing behind these faculties, a thing which can in itself never be measured? Sometimes we tend to define intelligence as something which remains constant in all environments. If we do so, the variations in a person's I. Q. will of course only measure differences in environment—in other words, degrees of social adaptation.

Besides these theoretical difficulties there are some practical sources of error in estimating the influence of environment on intelligence. If we find that people who are living under undesirable social circumstances tend to have lower intelligence quotients than those who are living in better circumstances, it is of course not valid to conclude anything with regard to the action of the environment on intelligence. The innate low intelligence of the individual, or of his ancestors, may be the reason why he landed in the unfavorable environment.

Much evidence, including the studies of Kaila in Finland and Mayer-Gross in Scotland, points to the conclusion that the movement of people is the main reason for the uneven distribution of intelligence. The more intelligent and energetic part of the population tends to leave areas where social conditions are becoming unfavorable, so that eventually these areas are inhabited by a kind of "residual population" with a high incidence of mental deficiency and other incapacitating anomalies. Further studies of population change are needed.

### *A Genetically Known Psychosis*

Among the psychoses, Huntington's chorea and schizophrenia present two very different problems in epidemiology.

Huntington's chorea is of special interest for two reasons: (1) The mode of inheritance is known exactly; (2) the disorder shows how much the clinical picture may vary in a disease which etiologically is sharply defined.

For a long time it has been known that in this disease the mode of inheritance is through a simple dominant gene. Every case of Huntington's chorea means that at least one of the parents had the gene and 50 percent of the children will become choreatic if they live long enough.

Until a few decades ago the clinical picture seemed rather monotonous. The disease seemed usually to begin between the ages of 30 and 50, starting with motor symptoms in the form of peculiar involuntary movements, which, after some time, were invariably accompanied by progressive mental deterioration. However, close investigations of families in which this disease has appeared have shown that there are many clinical variants. We are especially indebted to Friedrich Panse for furthering our knowledge in this respect. The disease may start in childhood. The mental symptoms may then take the form of mental deficiency, and the motor symptoms resemble those of Parkinsonism. If, on the other hand, the disease starts late in life, the mental symptoms very often are mild, and the motor symptoms take the form of a tremor which can only with difficulty be distinguished from senile tremor of other origin.

In some cases, however, the mental changes may occur many years before any neurological symptoms are recognizable. The mental deviations actually may appear in childhood and progress so slowly that a diagnosis of constitutional psychopathy is made. Following is an illustration:

A 30-year-old man was admitted to a hospital for a psychiatric examination to determine a legal question of his sanity. He had been sentenced several times because of aggressive behavior and, since he had again been violent without sufficient cause, it was thought that he might be mentally abnormal. During his stay in the hospital he appeared to have a somewhat primitive personality, but he was quiet and friendly. With regard to his assaults he could only tell that he had always been hot tempered and that very often he had been aggressive against people who teased him or were unjust to him.

This man had been born out of wedlock and did not know his parents. He had been adopted by a couple who seemed to be sensible and warmhearted people, who loved him, but who after a few years gave up keeping him at home because of his restlessness and aggressiveness. He was transferred to a children's home, where the same difficulties occurred. Nevertheless he was well liked, and the home managed to keep him until he was past school age. Then a suitable job was found for him and as he was a good worker he managed tolerably. But after some years his conflicts with others became more and more dominant until he was unable to keep a job any longer.

From this history different kinds of diagnoses could be made, according to the leanings of the psychiatrist. It could be urged that this was a classical history of a constitutional psychopath who in spite of good surroundings had difficulties everywhere. On the other hand, it could as easily be argued that this is a classical history of how children develop when they are not brought up in their own homes.

A third possibility, however, turned out to be more relevant. During the hospital stay it was observed that the patient had some motor peculiarities which on close examination proved to be of choreatic character. Then an investigation of the patient's own family was made. It was learned that his mother was a patient in a mental hospital, suffering from Huntington's disease, and that a number of other cases of this disorder had occurred in her family. Moreover, the mental symptoms which the patient had been displaying were in close accordance with symptoms which are very often found in choreatics even many years before their neurological symptoms begin.

This case illustrates rather well how much we have still to learn in clinical psychiatry, and how far we often are from being able to jump conclusively from symptoms to etiology.

### *Schizophrenia*

In Huntington's disease the etiology, the course, and the symptoms are well known. In schizophrenia everything is much more complicated and unknown in spite of the enormous forces which have been spent on research into causes.

Schizophrenia has been a most popular battlefield for representatives of the varying attitudes in psychiatry. Some people believe that the origin of the disease is genetic, others that it is biochemical-toxicological and still others that it is psychological. Actually, these different theories do not necessarily exclude one another. It is indeed possible to design a theory which includes all three kinds of etiological factors. In the present state of our knowledge such theories are speculative, yet they may serve as hypotheses for research.

What do we know today about the etiology of schizophrenia? We know that genetical factors must be of some importance; twin studies and genealogical studies seem to show this clearly. But we know nothing about the means which these pathological genes are using for producing schizophrenia. They might be of a physical or of a psychological nature. In regard to the physical possibility: As yet no anatomical differences between schizophrenics and normal people have been found nor has any distinctive physiological or biochemical process been observed in schizophrenics which are indicative of morbidity. The most interesting hints as to the way in which schizophrenia is produced have come from experimental psychiatry.

For decades attempts to produce schizophrenia experimentally with drugs have led to disappointment from a research point of view. This is not so surprising, for the symptoms of schizophrenia do not resemble the mental symptoms which appear when organic agents are interfering with the function of the brain. On the other hand, the schizophrenic symptoms do not accord, either, with the symptoms which are usually seen when a psychosis arises out of clear psychological origins.

However, a group of experimenters in Saskatchewan have recently induced psychotic states, through injections of adrenochrome, which are much closer to schizophrenia than any other experimental psychoses hitherto reported. Unfortunately, it seems to be difficult to reproduce the Saskatchewan experiments. But for the sake of speculation, let us assume that the adrenochrome psychosis is in some way related to the schizophrenic syndrome. We might then advance the following model theory:

Adrenochrome is a derivative of adrenaline. Conceivably, the normal adrenaline decomposition goes through an adrenochrome stage, but normally this must be of a very short duration since no intoxication arises. If for some reason this adrenochrome stage is prolonged, an intoxication, with schizophrenic symptoms, might occur. Possibly the genes which are the primary foundation for schizophrenia effect a disorder of metabolism resulting in a delay of the adrenochrome decomposition and consequently in an intoxication.

In some cases this disorder of metabolism might be so massive that the intoxication must occur under all conditions. In other cases the metabolic disorder might be less pronounced and only become manifest under circumstances in which there is a high production of adrenaline. We know that different kinds of physical and mental stress may stimulate adrenaline production. Perhaps it is especially furthered by some special kinds of psychological conflicts. In such cases the schizophrenia would be released by psychological conflict.

This is of course only a theoretical and imagined model. But it illustrates the fact that our current knowledge of schizophrenia is compatible with an etiological theory which includes genetical, biochemical, and psychological factors.

### *Neuroses and Psychopathy*

Two big groups of personality deviation—neuroses and psychopathy—are closely related to each other. They have many symptoms in common. Pure psychological mechanisms are essential in all cases. Nevertheless, it is practical to try to distinguish between two groups of patients: (1) Those who have, under all circumstances, a high probability of suffering from neurotic reactions, and therefore may be assumed to have some kind of hereditary or early-acquired predisposition for such reactions—the psychopathic personalities; (2) those who only under exceptional circumstances will produce neurotic reactions—the neurotics. However, it is often completely impossible to make a clear distinction in this regard in an individual case.

The groups of neuroses and psychopathy are so enormous and so heterogeneous, even when divided into subgroups, that confusions may easily arise. Here are two examples:

(1) Geneticists have made extensive studies on criminals. Some famous German twin studies seemed to indicate that crime arises on a genetic basis; that it is simply a fate. Some other German twin studies soon showed that this conclusion is not warranted. They showed that criminals fall into different groups. In some of the groups the deviation is mainly genetically determined; in others environment is the dominant etiological factor.

(2) Franz Kallmann in New York performed extensive and very careful twin studies on homosexuality. His conclusion was that homosexuality is to a very high degree genetically determined. His statement seems absolutely convincing and, consequently, very embarrassing for those psychiatrists who believe that many cases of homosexuality are psychologically determined.

On the other hand, early in the history of psychoanalysis Wilhelm Stekel drew attention to the fact that many male homosexuals come from a quite specific family set-up: They are pathologically attached to their mothers, who are very dominating, hysterical, or psychopathic persons bent on strengthening this attachment and preventing their sons from becoming attached to any other woman. The psychological mechanisms seem so obvious and convincing in these cases that it is very difficult to find room for a genetical hypothesis.

The explanation of this paradox is rather simple: The twins which Kallmann studied consisted mainly of homosexuals who had become social failures; in many cases, even criminals. Among them were many who were psychopathic, with no desire to conform to the moral tradition of society. Such cases of homosexuality may be mainly genetically determined. On the other hand, there is a group of homosexuals who consult psychiatrists. These individuals seem more neurotic than psychopathic; their homosexuality represents a serious life conflict for them. This is obviously quite another disease from the constitutional homosexuality in Kallmann's cases.

## *Genes and the Future*

Such examples have strengthened my belief that discordance between the genetical and other research methods in use within psychiatry does not necessarily exist.

It may be pertinent to ask where is the place of genetics in efforts to help children to grow up in a changing world? Those poor little particles, the genes, may not be in very high esteem in all circles; but at least they represent a rather stable and reliable part of the living creatures. Are they going to change, too?

We know, of course, that some changes have always occurred in the form of mutations. But mutations are very rare, indeed so rare that the selection process has been able to bring about an evolution of species through preference of plus-variants and eradication of minus-variants.

In recent years, however, some new factors—in the form of increased exposure to radiation—have been at work, which may cause a considerable augmentation of the number of mutations. Some of these will no doubt represent serious handicaps for the afflicted individuals. Unfortunately, at the present moment it seems impossible to give any reliable estimate of the dimensions of these risks. But that is of course just a question of time. In a few generations mankind will certainly know the answer.

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**A mother's love is a pretty crude affair. There is possessiveness in it, appetite, even a "drat the kid" element; there's generosity in it, and power, as well as humility. But sentimentality is outside it altogether and is repugnant to mothers.**

*D. W. Winnicott in* Mother and Child, *Basic Books, Inc., 1957.*

*Past events and cultural conflicts have produced problems for . . .*

# THE AMERICAN INDIAN CHILD

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IN MANY WAYS the American Indian child is a child apart from other children. His isolation from the main currents affecting other children is the result of many historical factors including the benevolent paternalism of his Government. In many cases he is also a child caught between two cultures, having lost much of the stability of the old and not having generally taken on control of the new.

Most Indian children are set apart from other American children by where they live and by their families' differences in language and customs. Moreover, their money and property are usually not under the same type of control as that of other children. their local government and court may be run by a tribe rather than a county, they may attend a Federal rather than a local public school, and they are likely to receive their health services from the Federal Government rather than from private physicians or from State and county services.

Often taught other values than those which are commonly stressed with other American children, the Indian child must try to live in two worlds. When he leaves the reservation, as at times he must, he has little help to make this a happy experience.

The Indian child on a reservation is surrounded by many adults who freely express feelings of dependency, inadequacy, and despair, and act accordingly thus producing an environment inimical to healthy living. The situation tends to prevent the child from having a normal approach to life, as it has his parents and even his grandparents. Too often the reservations in spite of their dances, feathers, and beads hold less glamour than misery for the children living on them. The trouble comes not so much from lack of money to help them, as from lack of the requisite understanding of them by others.

### *Who is an Indian?*

The general administrative and legal, but not anthropological, definition of an Indian is a person of one-fourth or more Indian blood, although different definitions have been made from time to time in relation to specific legislation.

Christopher Columbus' word "Indian" has no meaning to these oldest Americans except as a comprehensive term used to describe Federal relationships to them. The American Indian speaks of himself in terms of his tribe, "I am Sioux," "Cherokee" or "Modoc," as the case may be.

Considering the fact that the census enumerators of 1930, 1940, and 1950 had three different definitions of an Indian, based upon enrollment and admixtures of other blood, it is somewhat difficult to count the number in this country. However, the total number of Indians (including the native population of Alaska) who are for one reason or another some concern of the United States Government, probably comes to about a half million people, a little more than half of whom are minors.

Most of these Indians live in some 154 identifiable tribal jurisdictions, variously known as reservations, pueblos, colonies, or communities, which come within the responsibility of the agency offices of the Bureau of Indian Affairs. They are located in 20 States and Alaska. The largest are in North Dakota, South Dakota, Montana, Oregon, Washington, New Mexico, and Arizona. Oklahoma and Alaska are accepted as practically total jurisdictions in themselves, since in Oklahoma reservation lines have completely broken down although tribal groups have not, and in Alaska they were never established.

In addition to persons living on reservations or on other property held in trust for them by the Federal Government there are an unknown, but large, number of Indians living in the general population.

### *The Indian's Status*

Few general statements can be made about Indians in the United States, nor about any special responsibility the Federal Government has for them. The situation of every Indian derives from specific treaties entered into between his tribe and the Federal Government, from special legislation in regard to his tribe as well as from general legislation in regard to Indian affairs, from the legal status and activities of his own tribe, and from his status in the State in which he lives. Almost the only unequivocal statement which can be made is that as a result of a 1924 Act of Congress every Indian born in this country is a citizen of the United States.

In his person, the Indian is completely free, Government restrictions relate only to the property originally awarded his tribe by the Government.

The Indian of today is a product of the past, affected by literally thousands of Federal measures, some conflicting and some obsolete, taken over the years, first to control him, and later to redress wrongs done him or to "civilize" him and ready him for a life comparable to that of the dominant culture. Historical treaties with the Indian nations are still effective although no new ones have been made since 1871. Claims based on broken treaties are still being considered by the Indian Claims Commission,[1] and judgments awarding sums of money, often large sums, in reparation to the tribes have been made in recent years. Lands which were set aside, or lands to which tribes were removed as a war measure or because white settlers were greedy for their original lands, are still called reservations, although many of these are no longer tribally owned and are checkered with non-Indian ownership of plots sold by individual Indian owners. Government financial assistance to Indian families has replaced the rations first given by the Army as a substitute for the Indians' own way of life.

### *The Culture of the Indian*

Ben Reifel, Director of the Aberdeen Area for the Bureau of Indian Affairs, himself half Sioux and half of German ancestry, in examining the culture of the Plains Indians, has pointed out four ways in which they are apt to be different in attitude and outlook from most other Americans:

1. They are not future-oriented. For a thousand years they had no need to be apprehensive about the future. Therefore they found the essence of life in being, not in becoming.

2. Time is not important to them. The Sioux language does not even have a word for time. Their concern about the passing days is merely general, relating to natural phenomena like the sun, moon, and seasons.

3. Saving as a means of economic development has little meaning to the Indian. He has not needed to save to survive.

4. Habituation to hard work in order to earn a living has not been part of the Indian way of life, especially for the men.

Thus, we find today that many Indian parents lack ambition for their children; they have no zeal to get them to school on time; they have an urge to spend all their money, even the part belonging to their children, on a passing pleasure, and the father is disinclined to get a job or to go where he can get a job to support his family.

Culture is an ever-changing process, as human beings adopt what is desirable and useful to them. and discard what is not. Federal policy over the years, ambivalent in emphasis as it has moved from a program to separate the Indian from his culture to a program to restore him in it and then toward "acculturation," a middle ground which emphasizes the free choice of the individual, has not in the past nurtured in the Indian a receptivity to progressive change.

A report of conditions among the Indians issued by the Institute for Government Research in 1928, commonly called the Meriam report, referred to several past policies of the Federal Government as tending toward pauperization of the Indian people: "Having removed the Indians from their ancestral lands to restricted reservations as a war measure, the Government undertook to feed them and perform certain services for them which people normally do for themselves. The Indians at first accepted this aid as a matter of necessity, but promptly began to regard it as a matter of right, as indeed it was at the time and under the conditions of the inauguration of the ration system. They felt, and many of them still do, that the Government owes them a living, having taken their lands from them, and that they are under no obligation to support themselves."

Many Indians either still feel this way or for some other reason do not go where work may be found. As a result, in some months on some reservations most of the population are living on some form of Government financial assistance and receipt of benefits and insurances of one kind or another.

The Indians are in various stages of acculturation. Probably about half of them—or more than 200,000—have taken on aspects of the dominant American culture. This may or may not be good, largely depending upon what kind of contacts they have with others. What is badly needed is more contact, starting in childhood when possible, based upon a genuine desire on both sides for intercommunication.

The reservation system makes this difficult. A reservation is not, as has been charged before the United Nations, a concentration camp (unless it may be of the human spirit) nor is it the "museum piece" others have termed it. It is physical evidence of payment of a debt to the Indian people; but even more, it is home. People who leave the reservation do return, but many returnees leave again having acquired a taste for life off the reservation.

### *The Plight of Children*

On the reservations the normal pattern of American family life is never established for many children. This is partly due to lack of "know how" on the part of Indian parents, many of whom evince little interest in learning. However, little practical help or stimulation has been given them in this regard. Many of the parents themselves have been deprived of a satisfying relationship with adults in their own childhoods, and have consequently not learned to trust and relate to other people.

Considerable effort on the part of social workers and the Indians themselves would be required to put into general effect on reservations the following principles commonly regarded as desirable in family life in the United States:

A member of the Blackfeet Indian tribe rocks her grandchild to sleep in the tepee which serves as their home during the Sun Dance Ceremonial at Heart Butte, Mont. Child care among many Indians falls to the grandmother.

1. The father works and supports his family to the best of his ability.

2. The mother cares for her home and her children, keeping them clean, well fed, properly clothed, and happy.

3. Both parents maintain for themselves and establish for their family standards of morality.

4. The parents are concerned for the education and the future of their children.

Many Indian parents may accept these principles as desirable, and some certainly live up to them, but others are easily discouraged. Some seem to lack the "will to do" or to be skeptical of the effectiveness of effort. Others have apparently been so unhappy in their own childhoods that they are unable to care much about their children. The customary permissiveness of Indian parents in relation to children also hinders the development in the child of a disciplined approach to life.

Social workers and courts use the term "neglected" to cover various degrees of parental oversight. On Indian reservations where court neglect cases run far above the average the term is not used lightly. Too often it is apt to refer to a child needing hospitalization for malnutrition because nobody felt it important to feed him; or a child locked in the house for days, forgotten by parents carousing in town; or a child unwanted by the new man in his mother's life; or a 10-year-old child found drunk on the street at midnight.

Lesser examples of neglect also abound. Some parents fail to provide their children with such simple daily necessities as clean clothing and lunches for school. Some demand their children's money for their own use.

Naturally children react to such neglect with a variety of unhealthy behavior patterns, which are the despair of schools, courts, and social agencies. Individual children and young people are in crying need of the kind of adult understanding and support which can give them security and hope.

### *Federal Services*

The Federal Government accepts two major responsibilities for Indians: trusteeship for his lands and the money accruing from them; and social or developmental programs which are primarily an acknowledgment of a moral debt. In a sense the latter also stem from the land, for Federal services of a personal or community nature such as financial assistance, child-welfare services, education, and law and order are available only to Indians living on reservations or land held in trust for them.

However, no reservation or jurisdiction can exist without the need for State and local services, especially in these days of complex governmental services. Therefore in the early days of Federal grants to the States under the Social Security Act, the principle was established that wherever Federal funds are involved in public-service programs administered by State or local units the Indian's right is equal to that of any other person. Where State and local funds only are involved, States and communities sometimes balk at serving Indians because of the tax-exempt status of their lands. However, in many States funds for many of the services which the Indian requires along with other citizens are not derived from the property tax which he does not pay, but from other taxes which he does pay. Thus where normal sources of services fail to provide for Indians, the Federal Government sometimes gives services of a supplementary or a special nature to those who live on reservations or upon tax-exempt Indian-owned land.

Except for health services which are now provided through the Public Health Service of the Department of Health, Education, and Welfare, the Federal Government provides its services to Indians through the Bureau of Indian Affairs, first established in the War Department in 1824, and in 1849 transferred to the Department of the Interior where it still remains. The Bureau's history reflects over a century of varying congressional policy toward the Indians. Depressingly, Bureau reports of the last century present problems and proposals still being presented today.

At present the Bureau of Indian Affairs maintains under the Commissioner divisions of Economic Development, Resources, Administration, and Community Services. Community Services, the principal division concerned with children, has branches on education, law and order, and welfare. The work of all divisions and branches, however, affect the Indian child and his future. If an Indian wants to leave the reservation and broaden his knowledge of other places and people, the Relocation Branch may help his family to resettle in some city where work opportunities are plentiful. If the potentialities of an Indian child's property interests are to be realized, the conservation programs of the Division of Resources must protect his land, forest, or mineral rights, and help him through proper appraisal and leasing procedures to obtain optimal value for them.

Outside Washington and closer to the Indian people the Bureau maintains 10 Area Offices, 9 of which include an area social worker on their staffs and 5 of which include an area child-welfare worker or assistant area social worker primarily responsible for child welfare. The Area Offices supervise 56 agencies or field offices, 44 of which include 79 local social-work positions.

At the present time the social workers carry a variety of responsibilities in the different agencies, depending partly upon the local situation and partly upon the vision and inclination of the individual social worker. In some agencies the financial-assistance load is so heavy that it is impossible for the social workers to handle any other problems, especially in the winter months. In others, tribal assets are such that financial assistance is no problem so that the social worker can devote most of his time to services. Some social workers have even ventured into group-work and community organization. In all areas the social workers are giving special attention to securing adequate guardians for the protection of both the person and the property of the Indian child. Social workers have considerable freedom in developing program.

It has often been said that the greatest hope for the future of the Indian lies in education. Over half the Indian children of school age now attend regular community public schools, usually through contract with the State, while others attend day or boarding schools maintained by the Bureau of Indian Affairs. Vocational training is obtainable at a number of the boarding schools. Nearly 3,000 Indian children, most of the Navahos from homes far from any local school, live in 16 Bureau-maintained dormitories and attend nearby public schools.

The chief reason the Bureau maintains schools is the lack of other schools available to Indian children. However, 16 of its boarding schools and 4 of its dormitories also carry a large responsibility for the care of dependent and neglected children.

Being the principal resource for care of the school-age child away from his own home these boarding schools and dormitories have become a repository for children who have no parents or whose parents have abandoned them. They contain a great many children whose parents have separated and lost interest in them after taking on new partners and having other children. Many of the children were born out of wedlock and were first given by the mother to the maternal grandmother who when they reached school age turned them over to "Uncle Sam" and permanent residence in a boarding school. Some of the children were abandoned by their mothers immediately after birth and lived in hospitals until they were old enough to attend school.

Many other children in the boarding schools have been placed there for economic reasons alone by parents who are thus relieved of any necessity to support them.

Since the addition of child-welfare workers to the Indian Bureau's staff, emphasis has been placed upon keeping children with their own families whenever they can attend a local school, and making more suitable plans for the parentless or abandoned where possible, usually by contract with public or private social agencies. Inevitably the concentration of serious social problems in a boarding school or dormitory unequipped with the specialized staff to meet them produces serious behavior problems.

The Bureau of Indian Affairs considers its social-welfare program as supplementary to those of the States, which vary a great deal in their own programs. Some States make no distinction at all insofar as Indian children are concerned; others discriminate against them because of their tax-exempt land. However, even with the best intentions, child-welfare programs are so seriously understaffed in many States that they cannot provide full coverage to all children needing service, Indians or others. State child-welfare services are rarely available to children living on a reservation. Some States are plagued by court jurisdictional questions in protecting Indian children, although courts seldom refuse to take protective action for an Indian child.

### *Toward Self-Improvement*

Many concerned Indians believe that improvement in the lives of their people must come out of the thinking and planning of the Indians themselves. This thinking has already permeated some of the tribal councils which are taking steps to protect their children and to encourage young people to become more self-reliant. Educational funds totaling millions have been set up by 21 tribes to assure full educational opportunity for their young members. The Utes and the Jicarilla Apache tribes, which have considerable financial assets, have through action taken by their own legal counselors set up minors' trusts in trust companies in Denver and Albuquerque to protect their children's money.

Many tribes, concerned with the amount of drinking on their reservations, have established chapters of Alcoholics Anonymous and have encouraged treatment at rehabilitation centers or hospitals when indicated. Some tribes have established, through the use of both tribal and personal funds, a means whereby new or improved housing is made available to their members. Recently the Three Affiliated Tribes of the Fort Berthold reservation in North Dakota offered $1,000 as a prize to the winner of a community development contest.

Since few reservations are able to support their growing populations at a decent level of living, most Indian tribes are taking steps intended to help people still on the reservations to adjust to off-the-reservation ways of life. They are also holding intertribal meetings of an educational nature, such as the recent meetings on health problems, in Albuquerque, N. Mex., attended by members of the Pueblo and Navaho tribes, and the Indian Youth Conference which met in Washington last November under the sponsorship of Arrow, an organization of Indians and other persons interested in Indian welfare.

The encouragement of self-reliance is implicit in the most recent expression of Federal-Indian relationships. This is contained in House Concurrent Resolution 108 (83d Congress 1953) which states in its preamble:

". . . it is the policy of Congress, as rapidly as possible, to make Indians within the territorial limits of the United States subject to the same privileges and responsibilities as are applicable to other citizens of the United States and to grant them all of the rights and prerogatives pertaining to American citizenship. . . ." The resolution lists certain Indian groups which the Congress deemed ready to be freed from Federal supervision and control and from disabilities and limitations especially applicable to Indians. Subsequently, so-called "termination" laws were enacted affecting certain specified tribes, the largest and most prosperous of which are the Klamath of Oregon and the Menominee of Wisconsin.

### *What of the Future?*

Many Indians have found their own way to a more satisfying life and many more will do so. However, there is reason to be concerned about those who are undecided and fumbling, who waste opportunity, who are discouraged and doubtful. Their numbers are not great; a few hundred families on most reservations. A joint effort on the part of the tribes, the States and counties, the Bureau of Indian Affairs, and other appropriate Federal agencies should be able to produce a plan which might provide a spark of hope for each family.

Such a plan might include:

1. Provisions ensuring newborn babies and children under 6 of an environment which will break the vicious circle of unloved children becoming unloving parents.

2. Various steps, such as the employment of visiting teachers and promotion of parents' clubs, which can help parents understand and assume their responsibility for their children's home life and education.

3. Steps which can help families make more effective use of financial assistance and provide incentives to persons capable of becoming self-supporting to remove themselves from assistance rolls.

4. Steps to combat cultural patterns which are an impediment in present-day living. (Already ways are being found to deal with certain differences between the Indians and others in concepts of what is important. For example, one boarding-school adviser has set up a system for referring students to jobs, beginning with very simple tasks, and permitting progression only on the basis of proven responsibility such as getting to work on time.)

5. Steps which will help Indian children and youth to persist in their education, including the provision of educational and vocational guidance based on their individual capabilities.

6. Steps to make social services, including child-welfare services, available to families and children in need of them.

7. Community programs to enrich the life of Indian families on the reservations and to open the possibilities of life elsewhere to those who are interested. (How, for instance, can a community and its high-school students try to help the reservation children of high-school age who dread the prospects of attending public school?)

As an American citizen, the Indian should feel as free as any other person to come or to go and to use his resources as he himself wishes. He needs to shake himself free of the "Great White Father." If he is to live proudly in today's world he must adapt to the dominant culture while retaining those vestiges of his own culture which are useful or pleasant. And perhaps he will continue to make his own distinctive imprint on the general culture as he has with the corn he developed, the beautiful jewelry he has made, the paintings we now see exhibited in our galleries, and the songs and dances of ethnical significance by which he has related himself to Nature.

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[1] Act of August 14, 1954 (68 Stat. 718) as amended August 14, 1957 (71 Stat. 347).

**If you have a child and it's naughty do not strike it. . . . If you hit the child you will merely be putting more naughtiness in him. It has also been said that mothers should not lecture their children, that they merely make them bad by admonishing them.**

*From "The Teachings of My Father," in* Crashing Thunder, *autobiography of an American Indian, edited by Paul Radin.*

*How laymen and professional persons work together for children's health*

# A CITIZENS' COMMITTEE ACTS FOR CHILDREN

MARION R. ASCOLI

*Vice President and Chairman of Health Section, Citizens' Committee of New York City*

NEW YORK CITY is a wonderful place in which to live, but it is a difficult place to bring up children, even under the best circumstances. It is an overwhelming, overcrowded place. It has long contained many excellent organizations devoting their skills and their energies to various phases of child welfare, but until 12 years ago no one seemed to be looking intently at the whole picture—at what was being done, or left undone, for all the children in the city's five boroughs.

The Citizens' Committee for Children of New York City was founded in 1945 by a small group of lay persons and professionals who worked together during the war to bring about day-care services for the children of working mothers. When the war came to an end they felt that by joining forces with others they could bring into existence a citizens' committee which would tackle a larger number of problems related to children's welfare.

Today the Citizens' Committee has 122 members, including both interested laymen and experts from all the appropriate disciplines. They work together, with the help of a highly skilled and devoted staff, on all the facets of metropolitan life that affect children. The membership includes psychiatrists, pediatricians, social workers, nurses, a housing expert, a member of the city council, judges, and representatives of most city departments, and a hard core of knowledgeable, active laymen.

The committee's motto is: "Find the facts before you find fault and never make studies or surveys unless you know exactly how they are to be used." This combination of careful study and considered action is not easy to achieve, but it has won the confidence of other agencies and municipal and State officials. These turn to the committee more and more frequently for background material and for suggestions.

The committee always takes a positive approach to problems. Where it deplores it also recommends, and often works with city officials to improve and expand children's services. It publicly exposes shortcomings *only as a last resort*. When the committee does decide that an exposé is necessary it acts quickly and hits hard.

The members of the Citizens' Committee are chosen as individuals and represent only themselves. Therefore the committee has a useful capacity to act on short notice. This makes for flexibility and quick action in times of crisis. Crises are the committee's steady diet, for it not only maps out programs and points up needs, but also acts as a watchdog for the city's children and their families and tries to stop legislation or economies which might prove harmful to them.

The committee tries never to duplicate the work of any other group but to cooperate whenever possible with those who seek its help. Often after initiating

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**Based on a paper presented at the 1957 annual meeting of the American Public Health Associaion.**

a project it turns it over to a more appropriate body for further study or for action or both. Sometimes the committee plays a major, sometimes a minor, role in concerted community effort, but it is in on almost everything that concerns children.

In the annual battle of the budget the Citizens' Committee for Children is in the front ranks. Every year when the mayor's executive budget comes out the committee's staff makes a detailed analysis of all those parts that affect children's services. From this analysis emerges, after much effort, a picture of what the city proposes to do or to eliminate or to leave undone for children during the coming fiscal year. The committee shares this information with many other voluntary agencies which, thus armed, are later represented at the budget hearings to exert pressure on the board of estimate, the governing body which holds the purse strings.

The committee's structure has grown rather naturally out of its aims and its principles. Since one of its most important functions is to point out the unfilled needs of the city's children, it has established working sections in the main areas of child care and related fields. These sections have been altered from time to time as situations have changed.

Currently the committee has sections concerned with education, foster care, health, legislation, mental health, and protective services. The chairman is usually, but not always, a layman, on the theory that a layman has more time to devote to the job. Each section functions in a different way according to the work it has in hand. All chairmen are members of the board.

### *The Health Section*

The health section functions as a whole and also through subcommittees, each of which has its own chairman. At first the entire section concentrated its efforts on securing adequate maternal and child-health services. This involved working on personnel and budget problems of the city department of health, acting on State legislation, co-operating with the American Academy of Pediatrics in its study of child-health services and publishing a report, "Citizens Look at Their Health Services for Children."

As time went on the health section was able to turn its attention to the special services needed for various groups of children—for example, the handicapped in special schools and institutions. During this past year, the section's activities have included working on budget and personnel problems of the city health department, helping to plan a conference on perinatal mortality with other groups in the city, and looking at the effects on families of the high cost of prescription drugs.

The disastrous effect of the high cost of the new drugs on many family budgets was brought to the section's attention by the vice-chairman who is on the staff of the Health Insurance Plan of Greater New York, a voluntary prepayment medical-care plan. She reported that families not eligible for free medical care often cannot afford these drugs and that they therefore either do not have important prescriptions filled or go into debt or become indigent in order to have them filled. The investigations of the section's subcommittee showed that this situation was widespread enough to warrant attention.

Members of the health section are aware that drug companies have made enormous investments in manufacturing these drugs and that in due time prices will come down, but they also realize that new drugs coming on the market will continually present the same problem. The section's staff has now collated all the material collected, for presentation to the public and to the professional agencies which carry responsibility for medical care in the city and State.

### *Children in Hospitals*

Another of the health section's subcommittees is looking into an entirely different aspect of child health. It is making a survey of leisure-time activities for children in hospitals, both inpatient and outpatient. This is in a sense an outgrowth of a study the section made 2 years ago of hours for visiting children in local hospitals. The section began that study with a telephone inquiry to all the city's public and voluntary hospitals with pediatric beds in regard to their policies on visiting hours for child patients. Among 75 hospitals, the inquiry revealed wide variations in policy, ranging from 2 hours once a week to 5 hours a day.

Armed with this material and a well thought out questionnaire and prepared by a briefing session, the members of the subcommittee visited, by appointment, a sampling of these hospitals and a few outside the city. In addition, they wrote to many hospitals in other parts of the country to inquire about their policies. Wherever they found liberal visiting hours they made a point of discovering how long they had been in effect and what the key persons in the hospital, especially the doctors and nurses on the wards, thought of the policy. They also tried to find out who had instituted the liberal visiting hours.

A report of the committee's findings was published in the Journal of Pediatrics.[1] A recent telephone check of the 75 New York hospitals, just completed, has shown that about 60 percent of the original group have liberalized their schedules and many now permit parents to visit during most of the day. Although the committee cannot take full credit for this change it can rejoice that today fewer children are deprived of the comfort and support of their parents at a time when they have dire need of both.

The Committee's present study of leisure-time activities for children in hospitals, which the health section and the Play Schools Association of New York are conducting together, has the endorsement and cooperation of the United Hospital Fund and the Greater New York Hospital Association. The goal in this study is to discover, by visits to various hospitals, the kind of programs that exist, the personnel involved, whether paid or voluntary, and how well the programs work.

The committee members believe that a child who must stay in a hospital for any length of time should have some satisfying play materials and an appropriate program to help him pass the long hours; that a happy child will make a better recovery. They also believe that a good, if simple, recreation program in the outpatient clinics would make the long waiting hours more bearable for the mothers and the young patients and would help ease the strain on the medical staff.

## *Current Battles*

How the health section selects its areas of activity can best be illustrated by quoting from the staff's report for the winter 1956–57:

"In the health field it has been possible through the years to show how a group of citizens, laymen and professionals, can work in relation to the public departments. Each year the health section reviews the requests of the health department and works hard to secure support for the department's most urgent needs in the child health field. These needs have changed with the city's changing living patterns. It became important, as more and more mothers went to work, to make sure that day-care centers provided adequately for the health and safety of the many small children who attended them. As apartments became smaller, and many areas in the city more congested, summer day camps were established and must now be inspected to be sure they meet minimum standards in order to safeguard the 100,000 children for whom these camps are responsible."

The health section's struggle to obtain recognition and adequate salaries for professional health personnel was begun in 1945 and is still going on. The section has explained to the city's budget director the difference between a public-health nurse and a hospital registered nurse. It has prepared material on the reclassification of the medical personnel in the city's health and hospital departments. It has testified at many hearings, and during the past year worked successfully for the reclassification of the job of assistant commissioner in charge of maternal and child health.

## *Perennial Problems*

Some battles seemed to have been won only to flare up again. The neonatal mortality rate, which for New York City as a whole is low, is rising dangerously in areas inhabited largely by Puerto Ricans and Negroes. On other problems the health section has been plugging along over the years without being able to bring about any substantial improvement.

Many children between the ages of 1 and 6 are receiving no regular health supervision. The city's child-health stations do not have enough medical personnel to cover all these children. Sometimes diseases or disabilities in preschool children, which could be successfully and quickly treated if found early, do not come to anyone's attention until irreparable damage has been done. This is false economy.

Thirty-one public high schools and many parochial high schools receive no health department service at all. This means many youngsters of high-school age also receive little or no health supervision. Dental services for children are completely inadequate and no public dental service is available to high-school children. The intense battle—so far unsuccessful—for water fluoridation will have to go on, and so will pressure for additional dental services.

Sometimes a flicker of interest can turn into a major project. Several years ago, a representative of an agency dealing with handicapped children recommended the opening of a special school for these children. A committee staff member who heard this arranged for him to discuss his idea with members of the committee. As a result of this and ensuing conversations, the committee invited representatives of some of the leading groups dealing with physically handicapped children to discuss the problem of their education. Representatives from the city and State departments of education and health as well as experts from the committee's membership, including educators, psychiatrists, social workers, physicians, and recreation specialists were also invited.

From these meetings came a series of recommendations toward the improvement of the education program for physically handicapped children. They did *not* include a separate school, but *did* include recommendations affecting transportation, teachers' training, school building design, and organization of classes. The recommendations were presented to the mayor's advisory council. One of them—that severely handicapped children other than those with cerebral palsy be admitted to the school system's special classes—has now been realized. In addition, the Board of Education's new contract for the transportation of school children provides for 15 especially equipped busses built to transport children in wheel chairs and on crutches.

The health section is now trying to reexamine the most urgent needs in health services for children, in order to outline a program for the next year.

### *A Committee's Functions*

I have described activities of the health section to illustrate how varied are the activities and methods of the Citizens' Committee. The committee's other sections have also accomplished fine things. Studies of the juvenile courts have resulted in four books and a number of pamphlets which have attracted national attention and are having great influence locally. Another committee is wrestling with the knotty problem of the child who needs care outside his family, from the points of view both of providing adequate service and also of preventing this need. The legislative section studies all bills affecting children proposed in the city council and the State legislature and tries to push some and annihilate others. The education section is deeply concerned by the overcrowding and understaffing of the city's schools and by the problem of desegregation. The committee believes that the mental-health field in our city is chaotic, and an appropriate section is trying to develop ways to improve and coordinate existing services.

A citizens' committee for children can function in many ways and on many levels. It can make quick surveys or well-documented, definitive studies, initiate action or follow the lead of others, work with the city and State governments and encourage some legislation or try to discourage the bills which seem undesirable.

The members of such a committee should care deeply about children and young people. They must *not* be prima donnas but *must* be prepared to lead. They should have knowledge and convictions and be willing to work hard and work together. They must have good judgment about priorities since no group can cover all the facets of life in a modern urban setting. They must be disciplined enough to gather all relevant facts before taking a stand and must have the courage to speak out clearly when the right moment comes—even though the position they have decided on may not make them popular. This may sound like a large order, but there are, fortunately, many people who meet this description in every city and town in the land.

The staff of such a committee is of paramount importance. The executive director must have many qualities, among which are knowledge of the community and of children, tact, flexibility, a capacity for eliciting the best from the committee members, nerves of steel, and enormous vitality. A sense of humor is also a great help. The staff should include at least one good research person who can marshal facts and put them into readable form.

Every committee of citizens will follow a different pattern and will even change as it develops. It has the greatest chance of success if it is willing to start out modestly and grow slowly.

The Citizens' Committee for Children of New York has had many failures as well as accomplishments. It has tackled many perennial problems only to go down in annual defeat. However, little by little, over the years, it has alerted its fellow citizens to some of the dangers inherent in seeming economies and to the need for more and better services.

It speaks for the children of the city who cannot speak for themselves.

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[1] Liberal visiting policies for children in hospitals. A report by the Citizens' Committee for Children of New York City, Inc. Journal of Pediatrics, June 1955.

# THE REDUCTION OF ROLE CONFLICT IN INSTITUTIONAL STAFF

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CORRECTIONAL INSTITUTIONS throughout the United States today are undergoing a process of transformation. They are changing from relatively simple institutions with punishment, custody, and security as objectives to much more complex organizations with such difficult goals as vocational training, education, and personality and value reorganization superimposed on the older custodial expectations.

Such changes require fundamental redefinition of the roles which institution staff members must play, the relationships they maintain with one another and with their charges, and the various activities of their jobs. Basic conflicts are bound to occur in the process. Nowhere is this more clearly apparent than in the dilemma experienced by cottage staff, or houseparents, in juvenile institutions.

Older forms of correctional organization were based on highly authoritarian systems of relationship created to achieve the goals of custody and moral regeneration. The institutions operated through an established set of rules, the violation of which called for predictable forms of punishment. Classification took the form of grading offenders in terms of custodial risk.

In such systems the clarity of the objectives was matched by the clarity with which the role of houseparent was defined. He was expected to treat his charges all alike without regard to favoritism or special considerations arising out of individual need. Only in this way, it was thought, could order be maintained and justice be done. The houseparent who secured the greatest rule conformity by punishing rule violators consistently and impartially was evaluated most highly by the administration.

## *Sources of Conflict*

The current movement from this type of institution to one in which treatment interests are dominant precipitates a form of role conflict for cottage staff members. Where custodial requirements are minimized and treatment is stressed, they are faced with a dual obligation. On the one hand, they must continue to preserve order and discipline, since this is essential for keeping the institution going and a necessary precondition for effective treatment. On the other hand, they must individualize the handling of their charges according to the unique personality problems of each, so as to aid rather than hinder the therapeutic efforts of the professional staff.

The houseparent in this situation is confronted with a dilemma. The only way he knows of preserving order is to secure conformity to a set of rules which are clearly understood by all members of his cottage. His commitment to democratic values of equality and justice impels him to enforce these rules by punishing violators appropriately. However, he is told that punishment may often make treatment

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**Based on a paper presented at an advanced seminar in authoritative settings at the New York School of Social Work in December 1956.**

more difficult and that the proper attention to individual needs would make it unnecessary. He is torn between a recognition that an unenforced rule is no rule at all and an interest in abetting treatment efforts.

In most institutions the houseparent in this situation has little training and receives little help from his superiors. Ordinarily his supervisors are persons with greater seniority who have risen from the ranks. Frequently though they have learned to talk about the houseparent's role in terms of its treatment obligations they actually evaluate performance in relation to the houseparent's ability to run a quiet and orderly cottage. Constant referrals of disciplinary problems from a particular cottage mean to the supervisor that the houseparent is not doing a good job, an assumption based on the belief that if the houseparent understood his charges he could prevent disciplinary infractions. The effect of this type of evaluation is to reinforce the houseparent's control-treatment dilemma.

In most training schools too the houseparent receives little help from professional staff members. The latter work from a central office and carry caseloads of individuals scattered throughout the institution. They are not routinely faced with the problem of maintaining group control within a cottage. They tend to become isolated from the disciplinary responsibilities faced by the houseparent and to feel unprepared for and uninterested in intervention in problems of order or security. Interested primarily in therapy, they tend to assess the houseparent's disciplinary action in relation to its effect on the offending individual without regard to its consequences for other members of the cottage. They strongly resist the tendency of administrators and cottage staff supervisors to place primary emphasis on the maintenance of routine, order, and custody.

## *Trapped Houseparents*

The inevitable result of these various expectations of the houseparent is to produce considerable conflict between staff units—cottage, supervisory or administrative, and professional. The confusion arising as to the division of authority and responsibility is quickly aggravated and exploited by those juvenile offenders who are most opposed to the institution's goals.

Faced with the necessity of maintaining order and discipline within the cottage without anyone outside knowing of trouble, many houseparents resolve the dilemma by forming friendships with the natural leaders among their charges.[1] Through conferring special privileges and rewards on these persons the houseparent secures their help in controlling the activities of his other charges. This makes him vulnerable to threats of disciplinary violation unless he meets the young people's demands for control over cottage affairs. Thus, the most rebellious and hostile young persons become dominant and exact conformity from their more tractable peers.

The houseparent who is trapped in such a situation is apt to struggle to regain control through occasional inconsistent attempts to enforce his rules to the letter by meting out severe punishments for infractions. There follows a rash of runaways, riots, property destruction, and other rebellious behavior which cannot be hidden. Soon the old order is restored.

## *A Problem*

I have thus far described only a few of the major aspects of role conflict among houseparents in modern institutions for juvenile offenders. Many other pressures and counterpressures operate in this situation, and many variations exist in its form and content. I have, however, delineated the background against which one institution—the New York State Training School for Girls—set about trying to resolve the dilemma in the houseparent's problem of maintaining a quiet, orderly, but treatment-oriented cottage. The following description of this experiment and its effects derives from searching discussions with the superintendent and the members of his staff and from personal observation.

A change of management in this institution in 1953 resulted in a stronger emphasis on professional treatment goals. This transformation was directed by an experienced administrator trained in social work and committed to the values of his profession. He assembled a group of social workers to implement his program. The process of change was facilitated by a high turnover in cottage staff in the first year of the new administration, which made it somewhat easier to set up and enforce new role expectations for both cottage and professional staff.

In the beginning of the new administration the role definition for houseparents at this institution closely paralleled the conflicting expectations described in the preceding general statement. Cottage staff members were supervised by a small group of "seniors," former houseparents carrying supervisory and administrative functions. The seniors made up the institution's "home life department," a referral center for all administrative and disciplinary problems with which the cottage staff felt unable to cope. They provided the houseparents with guidance in carrying out their jobs and evaluated their performance. Though the seniors had acquired an ability to talk in terms of treatment objectives, their evaluations in effect reflected the degree to which the houseparents maintained discipline and order within the cottages and achieved an involvement of the girls in their care into institutional routines.

A houseparent's failure to fulfill these expectations was interpreted as a mark of incompetence and an evidence of inability to adopt a "treatment" orientation toward individual girls. As a result the houseparents felt that their requests to supervisors for support of disciplinary actions were handled in an inconsistent and unpredictable fashion. They could secure little guidance in resolving their basic dilemma—how to maintain a quiet cottage without interfering with individual treatment objectives when confronted with a group of girls largely hostile to the institution's purposes and informally organized for achieving their own ends.

The houseparents also felt unable to get full understanding of the nature of their problem or help in resolving it from the institution's social caseworkers. These formed a separate unit and were assigned their cases on an individual basis after the initial intake examination. Though they made numerous efforts to confer with the houseparents, communication centered about special problems of individuals. The caseworker was not prepared to deal with the houseparent's relationship with an individual girl as a part of the total context of relationships in the cottage. As a consequence the emphasis on solving problems of group discipline through understanding the treatment needs of the individual case only intensified the houseparent's basic conflict and sense of inadequacy.

The organizational arrangement made for division of responsibility and resulting confusion in regard to treatment and disciplinary decisions. It thrust back on the houseparent the basic task of resolving the role dilemma and tended to produce considerable hostility among the three staff units.

The caseworkers were not kept informed of what others were doing to persons in their caseload. They felt that both the seniors and the houseparents failed to work effectively because they were not basically oriented to treatment objectives and were not making an effort to understand and deal with the actions of individuals in relation to their treatment needs.

The houseparents' hostility reflected feelings of being abandoned and left to face their role problem without adequate understanding and support from their superiors. Under the pressure of day-to-day situations they resorted to devious ways of resolving their anxiety on an intuitive basis, but with relatively little success. Some retreated to a fixed and rigid set of rules which they enforced uniformly with whatever disciplinary tools were available to them within the cottage, while others developed cajoling relationships with their charges. In both cases the adjustment indicated an abandonment of treatment goals within the cottage.

The girls generally responded to this state of confusion and divided responsibility by manipulative tactics in which they sought to play various staff members off against one another. The houseparents shopped around for acceptable prescriptions in individual cases of misbehavior by presenting their problems alternately to the seniors and the caseworkers, frequently playing off one against the other. No single unit had access to all information known about an individual girl. Each unit pursued different objectives, collected different types of information about the girls, and arrived at different assessments of what ought to be done. The resulting intrastaff conflicts provided ample reason for the new administration to be concerned about their effect on both the custodial and treatment objectives of the institutions.

### *An Experiment*

In the face of these conditions the superintendent and his staff of social workers concluded that much more intensive and close supervision of cottage activities by professionally trained persons should be arranged. Consequently, the home life department and the casework service unit were combined into an integrated "cottage service department," with a trained social worker as director. Each social worker was assigned to supervise the activities of the girls and staff in two cottages.

At the present time 12 of the 16 cottages are under the authority of a social-work supervisor. The 4 remaining cottages are supervised by seniors, who also carry general troubleshooting responsibilities on the shifts to which they are assigned. The social workers have line authority over the staffs in the cottages under their direction and are expected to provide them with direct support and guidance in the handling of the girls. They are also required to provide treatment to the girls in these cottages.

This reorganization of the institution's structure firmly locates ultimate responsibility with the supervisors for all administrative, disciplinary, and treatment problems in the cottages. The social-work supervisors are also expected to provide routine evaluations and recordings on the work of the cottage staff. As a matter of practice, though they carry final authority for decisions, they make a conscious effort to share decision making with the cottage staff and to delegate authority to those houseparents who can safely and willingly assume it.

The effort is to present a united front to the girls of the cottage. Where a difficult disciplinary action has to be taken both the houseparent and the supervisor jointly present the decision to the offending girl. The supervisor refrains from openly countermanding inappropriate decisions reached by a houseparent but attempts to use the incident to prepare the houseparent for more adequate handling of similar cases in the future.

### *Relocation of Power*

The net effect of this change has been to relocate power in the hands of the supervisors, unify the authority structure, decentralize treatment and disciplinary decision-making to the various supervisory units, provide for professional attention to the total range of cottage problems, and preserve central control and continuity in the handling of individual cases.

The change was met by a considerable amount of initial hostility by houseparents. Some were afraid that they could not measure up to the social workers' expectations of them. Others felt that supervision by treatment-oriented social workers would challenge the disciplinary and treatment measures which they had evolved to maintain order. This hostility gradually turned to enthusiastic acceptance as the houseparents found that they could share the total range of their problems with their new supervisors, that the supervisors were ready to help with the complicated decisions posed by the necessity to carry on control and treatment simultaneously. The houseparents found that the basic role conflict with which they had been struggling was no longer theirs alone but could now be passed on or at least shared with the social-work supervisor.

Though the behavior of the girls improved during the integration experiment, the superintendent and his staff were primarily concerned with a "desire to increase, expand, and refine treatment techniques." In evaluating the results, consideration must be given to the experiment's effects on relationships among the staff, between the staff and the girls, and among the girls themselves.

### *The Results*

Insufficient time has elapsed for more than a brief observation of the apparent consequences. Furthermore, resources have not been available to support the independent, objective, and probing type of inquiry which is necessary to assess fully the impact of this staff reorganization at all levels of institutional activity. The following indications, therefore, drawn primarily from staff observations and reactions, should be viewed only as preliminary and suggestive:

**1.** In the structural change which took place, what has happened to the customary institutional role relationships between social caseworkers and houseparents?

The clear reorganization and clarification of the location of power, authority, and decision making have resulted in a redefinition of the duties of the social worker, making them more nearly coextensive with those of the houseparent. Problems of administration, cottage organization, and discipline have been added to the social worker's traditional concern with individual treatment.

The cottage staff has passed on its role dilemma to the new social-work supervisor. The houseparents are no longer expected to have the competency derived from training, philosophy, or experience to solve the basic conflicts of cottage life. According to the social-work supervisors, as a result of these changed expectations the houseparents are happier, more amenable to suggestions, less rigid in their relationships with the girls, more interested in understanding the girls' treatment needs, more flexible in disciplinary decisions, and more concerned with acquiring a reputation for running a well-adjusted cottage.

This concern with campus reputation indicates an interest on the part of the houseparents in conforming to a developing unified concept of their role. It also shows some willingness to be identified with the girls in the cottage, as well as with the supervisor, in a shared conception of achieving a "good cottage."

In general, a very marked increase in staff harmony has occurred through the minimizing of the basic sources of misunderstanding, competition for control, and factional pursuit of different objectives inherent in the former separation of role obligations.

**2.** What has happened by virtue of this organizational change to the traditional social-work relationship with the client?

Clearly a stronger authority identification has been built into the new role of the social worker. The social workers have expressed the opinion that the new role offers greater opportunities for treatment than formerly and that there is nothing inconsistent in the various duties or activities of this role from the standpoint of treatment effectiveness. The social-work supervisors have said that the girls do not restrict the information they offer about their problems any more than they did formerly. In fact, the girls seek the social workers out even more frequently and volunteer personal information just as freely.

The social workers report, moreover, that new sources of information drawn from the affairs of cottage life have been opened to them which have enhanced their ability to deal with the individual girl's personal problems. They are now able to relate these problems more successfully to the content of the girl's daily experience in her cottage. This has minimized misrepresentations in the girls' communications to them and has permitted more effective use of the realities of cottage experience as a treatment resource.

The administration places special emphasis on the contribution of the staff reorganization to the staff's ability to present a united front to the girls in the institution. The opportunity for the girls to exploit communication failures between houseparents and social workers has been largely eliminated. The new structural arrangement has greatly facilitated the exchange and sharing of information, thus blocking the girls' ability to manipulate staff and exploit staff misunderstandings as a way of solving or evading personal problems.

**3.** What has been the effect of the staff integration on the girls' relationships with one another and on their subsequent careers?

An adequate answer to this question would require much more intensive investigation of attitudes and relationships among the girls. While it seems clear that the new system has helped to lessen manipulative and deviant responses on the part of the girls in their relations with staff members, it is not clear how much the decrease in misbehavior is simply due to the greater control potential in the new staff arrangement rather than to greater acceptance and internalization of staff values on the part of the girls.

Possibly the increased centralization of authority among staff has been matched by a greater centralization of relationships among the girls and a heightening of the effectiveness of their informal controls over one another's behavior. The relatively untroubled smoothness with which the new integration has occurred suggests that the basic accommodations which formerly existed between the girls' informal organization and the official system have not been materially altered. The ease with which "acting-up" members are being controlled to preserve a good-cottage reputation suggests the presence of a fairly well-structured arrangement of roles set by the girls themselves. This would mean that the girls' values as opposed to administrative values are still intact, thus blocking effective internalization of official values except by the "squares" who already have them anyway.

### *Observation Needed*

The foregoing comments on the girls' relationships can only be advanced as a possible hypothesis of the girls' response to staff integration. Currently no evidence is available to provide a clear picture. Observations point to many advantages in the new staff organization from an administrative point of view. It greatly facilitates the management and control of the institutional population. It seems to offer greater opportunities for staff to pool their observations to arrive at more realistic treatment decisions in individual cases. Information is not yet available, however, to determine whether the benefits to the staff in their handling of the girls and in their relations to other staff members are matched by benefits to the girls in their peer experiences and in their subsequent careers.

The results thus far appear to be highly desirable and to point to the general success of the experiment. They also suggest the need for more intensive observations of the girls' responses.

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[1] Sykes, Gresham: The corruption of authority and rehabilitation. Social Forces, March 1956. (p. 257.)

# FILMS ON CHILD LIFE

**Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.**

WHERE THE GREEN GRASS GROWS. 20 minutes; sound; color; loan.

Records the experiences of 16 children with muscular dystrophy at a camp. Though limited physically, the children show the same joy in the same activities as do other children.

*Audience:* Citizen groups.

*Produced and distributed by:* Muscular Dystrophy Associations of America, 1790 Broadway, New York 19, N. Y.

A DESK FOR BILLIE. 57 minutes; sound; black and white or color; purchase or loan.

Depicts the story of a child following the crops with her migrant parents and her struggle to get an education.

*Audience:* Church and other lay groups.

*Produced by:* Agfra Films.

*Distributed by:* Sale: National Education Association, Division of Press and Radio Relations, 1201 Sixteenth Street, N. W., Washington 6, D. C. Loan: State educational associations.

FROM TEN TO TWELVE. 26 minutes; sound; black and white; purchase.

Illustrates the physical and emotional development of children of these ages by showing characteristics of their behavior and their attitudes toward parents, teachers, and each other. This film is one of the "Ages and Stages" series.

*Audience:* Parent-teacher association study groups; any group interested in children.

*Produced by:* Crawley Films for National Film Board of Canada.

*Distributed by:* McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 36, N. Y.

THE TEENS. 26 minutes; sound; black and white; purchase.

Shows the behavior of three teenagers in a family—a 13-year-old boy interested in his hobby, a 14-year-old active in his gang, and a 15-year-old girl well on her way to maturity but still dependent on her mother for emotional support. This film is one of the "Ages and Stages" series.

*Audience:* Parent-teacher association study groups; any group interested in teen-agers.

*Produced by:* Crawley Films for National Film Board of Canada.

*Distributed by:* McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 36, N. Y.

MAGIC IN SEEING. 22½ minutes; sound; black and white or color; purchase or rent.

Demonstrates a program for testing a school child's eyes, with referral to an ophthalmologist and fitting of glasses.

*Audience:* Parents; general public.

*Produced by:* Sam Orleans, with the cooperation of the National Health Council.

*Distributed by:* Sam Orleans and Associates, 211 West Cumberland Ave., Knoxville 15, Tenn.

A BABY NAMED X. 54 minutes; sound; black and white; purchase or rent.

Suggests how an adoption agency evaluates families applying for children and the kind of help it offers unmarried mothers.

*Audience:* Social-work students; caseworkers.

*Produced by:* NBC Television.

*Distributed by:* Child Welfare League of America, 345 East 46th Street, New York 17, N. Y.

EMERGENCY HOUSEWIFE. 14 minutes; sound; black and white; purchase or rent.

Shows how the Norwegian Government provides homemaker service to families when the mother is ill.

*Audience:* Parent groups; social-work students; general public.

*Produced by:* Norsk Film A/S, Norway. Norwegian commentary translated into English at the University of Southern California, Department of Cinema.

*Distributed by:* University of Southern California, Department of Cinema, University Park, Los Angeles 7, Calif.

YOUR VERY OWN. 17 minutes; sound; color; purchase or rent.

Illustrates steps taken by a social agency while considering the placement of a child for adoption in the home of a young Negro couple. Made for the Bureau of Adoption of California's State Department of Social Welfare, this film is designed to encourage adoption of children in minority groups.

*Audience:* Church and club groups; social workers and public-health nurses.

*Produced and distributed by:* University of Southern California, Department of Cinema, University Park, Los Angeles, Calif.

BOY IN THE DOORWAY. 28 minutes; sound; color; loan.

Tells of a boy's retreat from the world and shows how a residential treatment center for maladjusted children helped him conquer his problems; also how a family agency helped the boy's parents to prepare for his return to his home.

*Audience:* Mental-health societies; parent-teacher associations and other lay groups.

*Produced and distributed by:* Bellefaire, 22001 Fairmont Boulevard, Cleveland 18, Ohio.

BORDERLINE. 27 minutes; sound; black and white; purchase.

Points to some of the problems of emotional adjustment in adolescents and shows a teen-age girl undergoing psychotherapy at a small residential treatment center for emotionally disturbed children.

*Audience:* Parent groups; girls in a treatment center or training school.

*Produced by:* National Film Board of Canada.

*Distributed by:* McGraw-Hill Co., Text-Film Department, 330 West 42d Street, New York 36, N. Y.

# HERE AND THERE

## *Interdepartmental Committee on Children and Youth*

In the decade since the establishment of the Interdepartmental Committee on Children and Youth the number of Federal units of Government which coordinate their concern and activities for children through this device has risen from 11 to 34. Today's members come from 7 Departments and 7 independent agencies. Four of them—the United States Information Agency, the National Park Service, the Office of the Commissioner of Social Security, and the President's Council on Youth Fitness—became members within the past year.

The committee was established just 10 years ago this April as a result of a letter from the President to the administrator of the Federal Security Agency, predecessor of the Department of Health, Education, and Welfare. It met for the first time the following month.

From the beginning the committee has been concerned not only with exchanging program information but in looking into the broad needs of children. One of its earliest activities was to delve into conditions among children in Puerto Rico, which resulted in a report, "Needs of the Children of Puerto Rico," published in June 1950. This interest in gathering together information on the needs of special groups of children, as well as children in general, has continued over the years and has resulted in numerous publications, including reports on children of migrant farm workers, juvenile delinquents, children of working mothers and the mentally retarded.

Twice the committee has been aided in its inquiries by the advice and financial aid of the Josiah Macy, Jr., Foundation, with which it has jointly sponsored seminars for representatives of its member agencies. The first, on healthy personality development in children, was held in September 1951; and the second, on community planning for mentally retarded children, was held in February 1956. The proceedings of these seminars were published by the Foundation.

Shortly after its creation the Committee became deeply involved in planning for the Midcentury White House Conference on Children and Youth. In this it developed a close and continuing relationship with two groups, the Council of National Organizations and the National Council of State Committees on Children and Youth, with which it has sponsored four joint conferences on children and youth in the last 5 years. A joint committee of the three groups is currently assisting with plans for a 1960 White House Conference.

The Interdepartmental Committee meets once a month, with programs focused on keeping the membership informed of recent developments within the agencies and discussing common problems and concerns. Its activities are carried out through subcommittees composed of program staff designated by the member agencies. One subcommittee has recently published a leaflet to help community workers identify the problems of and resources for young people leaving school for work. Currently an ad hoc committee is planning a seminar for Interdepartmental Committee agencies about the problems of teen-agers who are not succeeding in school.

## *Homemaker Service*

A national conference to stimulate development of homemaker and related services throughout the United States is to be held early in 1959 at Chicago. Twenty-five national social and health agencies are cosponsors of the conference together with the following units of the Department of Health, Education, and Welfare: The Children's Bureau, Bureau of Public Assistance, Bureau of Old-Age and Survivors Insurance, and Office of the Commissioner, Social Security Administration; Office of Education; Office of Vocational Rehabilitation; Public Health Service; and the Special Staff on Aging.

These groups met in Washington on January 27 to discuss plans for the conference, which will be attended by about 400 persons. A study of homemaker service is now in process at the Public Health Service, and numerous other preconference activities to gather information and provide background material for the conference are being planned.

Some of the goals of homemaker service, as defined at the Washington meeting, are: Strengthening family life; preventing breakup of families on account of the mother's absence or illness; helping immature parents to give better care to children and home; assisting in the rehabilitation of the housewife or other ill or disabled family members; and permitting older or chronically ill people to remain at home.

## *About Health*

An experimental 3-week institute to train nurses in leading discussion groups for expectant parents has just been completed in Dallas, Tex., by staff members of the Child Study Association of America, under the sponsorship of the Children's Bureau, the Texas State Department of Health, and Texas Woman's University. Local obstetricians, pediatricians, and psychiatrists are assisting in the project. The nurses attending come from five States: Texas, Louisiana, Oklahoma, Arkansas, and New Mexico. The institute staff is now providing consultation service to the nurses in their States. A followup institute will be held later in the year.

In 1954 a similar program was given by the association, under sponsorship of the Children's Bureau and the New York State Department of Health. Earlier the association has held programs of this type for social workers and educators.

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The National Congress of Parents and Teachers is calling on local, State, and national health organizations for cooperation in carrying out a program to promote continued health supervision for all children. As a result of recommendations made at a special conference of representatives of health organizations and Government agencies, held 2 years ago, the congress is urging local parent-teacher associations to expand their "summer round-up" programs, hitherto focused on health appraisal of children at school entrance, to encompass a concern for children's health from birth through their school experience.

Among the specific educational and promotional activities the Congress has suggested for local PTA's in connection with this program are: Interpretation of the uses of health facilities and the importance of preschool health as preparation for school attendance; surveys to ascertain those children not receiving continuous health supervision; cooperation with other agencies in developing a program for periodic health appraisal and in the development of school health councils; recommendation of general health examinations by family physicians; aid in the development of cumulative child-health records; the promotion of research in child-health programs.

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Since last October construction contracts totaling more than $1,200,000 for health facilities for American Indians have been authorized by the Public Health Service, U. S. Department of Health, Education, and Welfare.

The construction will include 22 housing units on or near Indian reservations in the Southwest; additions to the Indian hospital at Tuba City, Ariz.; a field health center at Kayenta, Ariz.; 4 field health stations in South Dakota; and water and sewage facilities at Crown Point and Zuni, N. Mex., and Chinle, Ariz.

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The Public Health Service recently announced new grants totaling more than $300,000 for its nationwide research program directed toward development of preventives for cerebral palsy, mental retardation, and related neurological disorders. The participating institutions are Charity Hospital, New Orleans, and Columbia University, New York. They received $168,167 and $150,000, respectively.

The two new awards bring to 13 the number of medical schools and hospitals engaged in the collaborative study. The other 11 medical centers participating in the study are: New York Medical College; University of Oregon Medical School; Yale University; Brown University; Medical College of Virginia; Children's Hospital, Philadelphia; University of Pennsylvania; Johns Hopkins University; Children's Hospital, San Francisco; University of Minnesota; and Boston Lying-in Hospital. These centers have received grants totaling about $2.1 million since the study began in 1956.

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To help prevent goiter in an area in India, the United Nations Children's Fund (UNICEF) recently approved a project for enriching salt with iodine. This is the first project of its kind to receive aid from the Fund.

## *Juvenile Delinquency*

The New York City Youth Board has reported some tentative observations of the first 4 years of its 8-year study to test the validity of the Glueck "social factors" scale for discovering early proneness to juvenile delinquency ("Delinquency Prediction—A Progress Report").

The project began in the school year 1952-53, when the Youth Board studied the family life of more than 200 young boys, including every boy that entered the first grade in two public schools in a high-delinquency area of the city. Information on the parents' treatment of the boy and on the cohesiveness of the family was collected through home visits, reports from social agencies, and clearance with the social-service exchange. On the basis of this information Youth Board workers, using the social-factors scale presented by Sheldon and Eleanor Glueck in their book, "Unraveling Juvenile Delinquency," judged each child's probability of eventually becoming delinquent and assigned each a percentage representing that probability. About one-third were rated as having more than a 50–50 chance of becoming persistent delinquents.

At the time of the original rating boys for whom the chances of becoming delinquent were predicted to be at least 50 percent were referred to a child-guidance clinic.

At the end of the 1955–56 school year the Youth Board examined the status of each boy's behavior on the basis of school and social-agency data and court or police records through 1956. At the same time Youth Board workers compared each boy's behavior with his early rating on probability of becoming delinquent. As they expected with children so young—in the fourth school grade—few could be classified as persistent delinquents.

Of the 109 boys rated as having the least probability of later delinquency, 74 (68 percent) were in the group characterized 4 years later as "normal." Of the 66 rated 4 years earlier as having more than 50 percent probability of delinquency, 24 (36 percent) fell in a group classified as showing either "delinquent traits," "antisocial behavior," "mental illness," "unofficial delinquency," or "official delinquency," with 8 in one or the other of the last two classes.

Copies of the report are available from the Youth Board, 79 Madison Avenue, New York, N. Y., at $1.

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Three-quarters of the children in public institutions for delinquents in 1956 were boys, according to information received by the Children's Bureau from 139 such institutions. The median age was close to 16 for boys as well as girls.

One-half of the institutions had capacities of over 150 children; 4 out of 10, over 200. (According to standards established by the Children's Bureau and the National Association of Training Schools and Juvenile Agencies, the capacity of training schools should be limited to 150.) About 3 out of 10 institutions were housing more children than their rated capacity.

The average length of the stay in the 139 institutions was 11 months for boys, 14 months for girls. Nearly one-sixth of the children admitted during 1956 were returned to the institution because they had violated parole or committed a new offense.

These findings are based on data compiled by the Children's Bureau in 1957, about which a full report will be published soon.

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The number of local probation officers in the United States serving only juveniles increased by nearly one-fourth between 1952 and 1957, and the number serving both juveniles and adults rose by nearly two-thirds, according to the thirteenth edition of the Probation and Parole Directory, published by the National Probation and Parole Association (1957).

## *Work Project*

In Newark, N. J., plans are now under way for the second year of a day work camp for teen-age boys of a depressed neighborhood, a joint project of the Fuld Neighborhood House and the Essex County Park Commission.

The project was initiated last summer in an effort to promote self-esteem among a group of boys who besides being insecure in their home environments seemed to have a general feeling of being unwanted and unappreciated. The Essex County Park Commission provided the location, work assignments, a foreman, tools, and wages, while the Fuld House selected the participants and provided educational supervision and transportation.

The 15 participants—all Negro boys between the ages of 15½ and 18—were paid $1 an hour and worked for a 7-hour day, with an hour off for lunch, for a period of 6 weeks, clearing and reconstructing trails and digging rain ditches in a county park. They took their own lunches and paid 50 cents a day for carfare. Two boys dropped out after two weeks but were quickly replaced.

An account of the last summer's experiment, combined in a report of the agency's 1957 summer-camp program, indicates that the few crises which occurred, stemming from the boys' inexperience and insecurity, were surmounted by the skilled group leadership provided by the agency and by the good nature of the boys themselves.

A report of one of the agency's group leaders recommends that a future experiment be interracial and offer the boys the same hourly wage rate but fewer hours of work, thus making the project a combination of work and play. Some of the boys in this their first job could not keep up such hard work for 7 hours, he explained, and he suggested that paying them in full for less than full time "does not build up healthy attitudes for future jobs."

## *Child Welfare*

A new juvenile code was adopted in the 1957 session of the Kansas legislature, the first major change since 1905. In general the legal procedures have been formalized. Children and parents have been given greater protection in such matters as notice of court hearings, provision for guardian *ad litem*, and appeal.

In an attempt to individualize treatment and relate the disposition in children's cases to the reason they were brought before the court, the law provides for the following classification: truants, traffic offenders, wayward children, miscreants, delinquents. Disposition by the court is limited according to the classification for which the child qualifies by reason of the behavior bringing him to the attention of the court. Only in the cases of delinquent and miscreant children can the court commit children to training schools.

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In Missouri the foster-care section of the Missouri Council for Children and Youth is currently carrying out three study projects. Their purposes are to determine: (1) The need for day-care services for children of working mothers in St. Joseph County, an industrial-rural county of approximately 200,000 persons; (2) the characteristics of, availability of adoptive homes for, and results of adoptive placements of children with special needs in adoption; (3) the characteristics of children discharged from care during 2 months of 1957 by 39 foster-family care and group-care agencies.

In the same State the Division of Welfare has recently completed the fact gathering in a study of 1,001 children in foster-family care under its auspices. Purpose of the study is to learn the characteristics of these children in relation to age; legal status; physical, mental and emotional state; length of time in foster care; availability for adoption; and the characteristics of their parents in relation to physical and emotional availability for casework, relationship to the child and the reverse, and the development of status toward parenthood.

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In an attempt to determine conditions affecting decisions about children who have need of foster care, the Child Welfare League of America, with a grant from the Field Foundation, has begun a study of such children in 9 counties in various regions of the country. With the cooperation of the local foster-care agencies and councils of social agencies, and the appropriate State departments of welfare, two League field teams, each consisting of a social worker and a sociologist, are studying the characteristics of children in foster care, of their own families, of their foster families, of the communities, and of the policies and practices of the social agencies responsible for them. The children's characteristics will be compared with those of children whom the same agencies have placed for adoption and of children they have returned from foster care to

## A MATERNAL AND CHILD-HEALTH TEAM IN IRAQ

**Now completely composed of Iraqi personnel, the staff of the maternal and child-health center in Samawa, reported on in CHILDREN 3 years ago by Dr. Elizabeth Peabody Trevett (March–April 1955, page 56) has extended its services to two other Iraqi towns, Khidr and Rumaitha. Here members of the team await the debarking of sheep from a ferry that will carry the team on the way to Khidr to conduct a prenatal clinic. Last summer after a period in which Dr. Marie Lehner, succeeding Dr. Trevett, helped the expanding Iraqi staff to assume full responsibiltiy for the center, the last members of the American staff were withdrawn.**

parents or relatives. A local advisory committee will be established in each community to work with research staff and participating agencies.

The report of the study is expected to be completed early in 1959.

## *Migrants*

Crop-following families have health and welfare problems similar in both quality and quantity to those of persons in comparable nonmigrant groups but their attitudes toward them are often different, according to a report of a 12-month study of the day-by-day problems of 202 Negro families in the Florida to New York agricultural migrant stream.

These attitudes, such as an acceptance of sickness or unemployment as a part of life, the report notes as among the important barriers to their receiving needed services. Others are: the unevenness of availability of services among the States through which they travel, thus preventing the establishment of a pattern of expectancy; ignorance of what services are available; lack of understanding of the migrants' cultural and social conditions among persons who have services to offer, resulting in failures in communicative efforts; a lack of integration in services, both locally and on an interstate basis, which prevents the migrant from receiving the kinds of services requiring over-all planning or long-term treatment.

The report suggests two "points of entry" in getting the migrants to accept services—day care of children, which is popular where available, and work with crew leaders toward their greater understanding of the migrants' problems.

The study, which the Bureau of Maternal and Child Health of Florida's State Board of Health carried out with the help of a grant from the Federal Children's Bureau, was planned as a step toward helping health and welfare agencies understand migrants' needs better and thus meet them more adequately.

After a 2-month gathering period spent in Florida, during which a U. S. Public Health Service physician assessed the physical condition of many of the migrants, the group started north in May with its crew leader, accompanied by a research investigator After traveling through eight States, and stopping for various lengths of time to work on such crops as tomatoes, beans, potatoes, peaches, and apples, with the longest stops in Virginia and New York, the group returned to Florida in November.

During a stop in Virginia the investigator was joined by a Negro "participant-observer," who worked as a member of the labor crew and collected information on the problems of the group.

The report, "They Follow the Sun," by the project director, Earl Lomon Koos, was published by the Bureau of Maternal Health, Florida State Board of Health, Jacksonville, 1957.

## *ADC*

In an analysis of families receiving aid-to-dependent-children payments, the Bureau of Public Assistance has found that in 1955 more than 50 percent of them were families in which the father was divorced or separated from the mother, had deserted her, or had never been married to her. Seven years earlier the percentage of families with estranged fathers was 46, and 6 years before that it was only 36.

Although some of the increasing proportion in the ADC program of families with estranged fathers is due to support of orphans through the old-age and survivors insurance program, most of it, the Bureau reports, is due to a rising trend among the population as a whole in family breakups other than by death, with resulting low income in the broken families.

In regard to the possibilities of the mothers' being able to support the children by themselves, the Bureau cites census figures showing that in 1954 nearly one-fourth of all female heads of families had no personal income and the median income of families headed by a woman was only about half that of families headed by a man; and that the economic condition of families with a female head showed no improvement between 1948 and 1954—years when the income of families headed by a male improved substantially.

In the summer of 1955 a total of 323,600 families received payments under the program for aid to dependent children because of estrangement of the father. The total included 185,500 families, with 527,400 children, in which the father was currently or previously married to the mother of the children, and 138,100 families, with 308,800 children, in which the father never was married to the mother.

In more than 1 out of every 7 cases, the absent father contributed to the support of his family in the study month. A smaller proportion of the fathers who were never married to the children's mother contributed (1 in 10) than of those who were otherwise estranged (slightly less than 1 in 5).

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Forty-two of the 53 jurisdictions with aid-to-dependent-children programs have added first cousins, nephews, and nieces to the specified relatives with whom a child receiving aid may live. The additions came after a 1956 amendment to the Social Security Act lengthened the list of relatives with whom children may live and receive assistance with Federal financial participation. Previously such relatives were limited to parents; grandparents; brothers and sisters; stepparents, stepbrothers, and stepsisters; and uncles and aunts.

## *Vital Statistics*

According to information from the National Office of Vital Statistics:

Preliminary estimates of the number of babies born in the United States during 1957 indicate that a new high has been reached for the seventh straight year. The 1957 total is expected to be about 4,318,000, or 98,000 ahead of the 1956 record. The 1957 total is a projection from the number of babies estimated to have been born in the first 9 months of the year.

Recent yearly increases in births are believed to be the result not only of an increase in the number of marriages but of a trend toward larger families. The number of families with three or more children has been rising for several years. In 1955, the most recent year for which final figures are available, the number of third children born rose to 800,000, an increase of 1.9 percent over the 1954 figure, and the number of fourth children and above increased by 6.9 percent—to 1,100,000. Marriages during 1956 totaled about 1,585,000, an increase of 3.5 percent over the number in 1955.

The expected 1957 record in births will represent a birth rate of 25.3 for each 1,000 persons in the population, compared with a rate of 25.2 for 1956.

Nearly 4 percent more children were born out of wedlock in the United States in 1955 than in 1954, according to estimated figures for both years. The rate of such births per 1,000 unmarried females 15–44 years of age in the population rose from 18.3 in 1954 to 19.3 in 1955. The ratio of births out of wedlock to 1,000 live births increased from 44.0 in 1954 to 45.8 in 1955.

As in previous years the largest group of mothers who gave birth to these children were 15–19 years of age (68,900); the second largest group 20–24 years (55,700).

## *Miscellany*

The first of a new series of pamphlets on human relations, called the One Nation Library Series, was recently issued by the Anti-Defamation League of B'nai B'rith in cooperation with the Joseph Kaplan Project in Intergroup Education. Designed primarily for senior high school students and young adults, each of the series is accompanied by a teachers' guide. The first pamphlet, entitled "Prejudice: how do people get that way?" is written by William Van Til, professor of education and chairman of New York University's department of secondary education. Copies available at 25 cents from the League, 515 Madison Avenue, New York 22, N. Y.

Forthcoming pamphlets will include discussions of: the place of Jews in the United States, by historian Oscar Handlin; stereotypes, by psychologist Otto Klineberg; and the international implications of minority-group tensions by novelist James Michener.

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Why some clients continue with family-service agencies and others drop out is the subject of a study co-sponsored by the Research Center of the University of Chicago's School of Social Service Administration and the Family Service Association of America. The study is planned to confirm the findings of an earlier one carried out by the same two groups.

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Child-development and family relationship groups, meeting as part of the U. S. Department of Agriculture's Federal Extension Service program, carried on in cooperation with State and county services, now enroll 1,700,000 persons, including fathers as well as mothers.

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Noting that mental illness occurs in childhood as well as at all other ages, the National Association for Mental Health reports that in this country about 2,500 children are now in 40 residential treatment centers for children with serious emotional disturbances and that about 4,000 children and young people are admitted to State hospitals each year. The association also estimates that at least 200,000 children and adolescents will attend mental-health clinics this year.

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# INTERNATIONAL PUBLICATIONS

**ANNUAL EPIDEMIOLOGICAL AND VITAL STATISTICS, 1954.** World Health Organization, Palais des Nations, Geneva, 1957. 617 pp. For sale by Columbia University Press, New York. $10.

Among the data in this volume are statistics for 20 countries on deaths from complications of pregnancy, childbirth, and the puerperium; and deaths in children from infective and parasitic diseases, malignant neoplasms, chronic rheumatic heart disease, and motor-vehicle and other accidents.

Causes of death in children under 5 years are presented for 32 countries by sex and by detailed age groups: 1 day; 1–6 days; 7–27 days; 2 months; 3–5 months; 6–11 months; 1, 2, 3, and 4 years. Statistics relating to causes of death in the general population are given by sex and age for 42 countries (as against 35 in the previous volume).

Figures are included on health personnel—physicians, dentists, midwives, nurses, pharmacists, and veterinarians; on hospitals and other hospital establishments; and on vaccinations against 11 diseases.

The six previous volumes of this series covered the periods 1939–46 and 1947 49 and the separate years 1950, 1951, 1952, and 1953.

**JUVENILE EPILEPSY**; report of a study group. World Health Organization Technical Report Series No. 130. Palais des Nations, Geneva, 1957. 44 pp. Columbia University Press, New York. 30 cents.

Viewing the problem of epilepsy in children from many aspects—physiological, pediatric, psychiatric, genetic, and social—this report includes a review of current clinical and laboratory research and sets forth a plan for medical and social treatment of epileptic children, including public-health and educational measures; and family counseling, including genetic advice.

Public-health measures recommended by the group include: Study of incidence and prevalence of epilepsy, nationally and internationally; continuing care of the individual patient; education of medical personnel, with special attention to the medical student; family-guidance services; education of the public in an intelligent attitude toward epilepsy; and research into prevention and treatment methods.

**INDUSTRIALIZATION AND SOCIAL WORK**: proceedings of the Eighth Assembly of the International Conference of Social Work. Carl Heymanns, publisher, Cologne and Berlin, Germany. 1957. 922 pp. $5.25.

Recognizing that industrialism, though desirable as a means of improving people's economic life, is often accompanied by various pressures and dislocations, the representatives of 55 countries who made up the international conference reported in this book met to exchange views on what social work can do toward helping people adjust to life in an industrial society.

The conference members divided into 20 groups to discuss indutsrialization in relation to such topics as: Juvenile delinquency, employment of mothers, vocational guidance of youth, nutrition, housing, family allowances, mental health, and leisure problems of working youth.

The book reports the proceedings in English, French, and German.

# BOOK NOTES

PSYCHIATRIC INPATIENT TREATMENT OF CHILDREN; report of the conference on inpatient psychiatric treatment for children, held at Washington, D. C., October 17–21, 1956, under the auspices of the American Psychiatric Association and the American Academy of Child Psychiatry. American Psychiatric Association. Washington. 1957. 1954 pp. $3.50.

After presenting a brief history of the development of psychiatric services for emotionally disturbed children in residence in medical institutions, this book discusses the relation between the children's psychiatric hospital and the community; the planning and financing of such a hospital; its administration and personnel; the treatment program; and research needed for its successful operation.

Among the needs of children's psychiatric hospitals the book cites: establishment of a comprehensive legal code concerning children's admission to psychiatric hospitals and treatment there so as to provide legal protection for the child and a clear medical designation of guardianship responsibility; provision of an adequate budget for medical care of children under psychiatric treatment; improvement of diagnostic classifications in child psychiatry; and epidemiological studies of the need for the type of services discussed in the book.

THE CASEWORK RELATIONSHIP. Felix P. Biestek. Loyola University Press, Chicago. 1957. 149 pp. $2.40.

Defining the casework relationship as the dynamic interaction of attitudes and emotions between the caseworker and the client, the author, a member of the faculty of Loyola University School of Social Work, discusses seven principles of this relationship. These are: individualization, purposeful expression of feelings, controlled emotional involvement, acceptance, the nonjudgmental attitude, client self-determination, and confidentiality. Each of these principles, the author says, is founded on one of the basic needs of the client, which he lists as: to be treated as an individual; to express his feelings; to be accepted as a person of worth; to have his feelings understood sympathetically; not to be judged; to make his own decisions; to have the information disclosed in interviews kept confidential.

In the casework relationship, according to the author, the social worker is expected to be both a realist and an idealist. As a realist, he is expected to see, understand, and help with the hard, sometimes ugly and repulsive, realities in his clients' lives; as an idealist, to recognize in a practical way the dignity and nobility of people, even if they have lost respect for themselves.

THE PSYCHOANALYTIC STUDY OF THE CHILD, vol. 12. Edited by Ruth S. Eissler and others. International Universities Press, New York. 417 pp. $8.50.

Four groups of papers are included in this volume, under the headings, Contributions to Psychoanalytic Theory, Aspects of Early Development, Clinical Contributions, and Applied Psychoanalysis.

THE COMPLEAT PEDIATRICIAN; practical, diagnostic, therapeutic, and preventive pediatrics. Wilburt C. Davison and Jeana Davison Levinthal. Seventh edition, completely rewritten. Duke University Press, Durham, N. C. 1957. 257 sections (no pagination). $4.25.

First published in 1919, this book was originally written as "a notebook of easily forgotten facts and methods," and still is intended to serve as a "ready reminder," to jog the pediatrician's memory, "though it cannot do his thinking for him." The present edition states that preventive pediatrics has made more progress in the past 50 years than in the preceding 50,000. In addition to chapters on specific types of diseases and their management, it includes chapters on: growth, development, and general care of children; prematurity; and the reduction of mortality.

BAFFLING EYES OF YOUTH. John K. Donohue. Association Press, New York, 1957. 251 pp. $3.50.

This is the story of a probation officer and a gang of boys who grew up together between 1928 and 1940 in St. Paul, Minn. The basic material comes from a diary the author kept in connection with his work. Only the names of the boys and their families are fictitious. While recognizing that the times and conditions under which the boys grew up were different from those encountered by young people today, the author presents his experiences for their possible helpfulness today.

Although the judge had ordered the boys not to associate with each other, the author realized that it was important to keep them together, providing them with group activities such as sports of the team variety to divert them from antisocial pursuits. It took several years before the lessons in cooperation and in socially acceptable behavior had any appreciable effect, and more time including considerable backsliding until the majority of the boys had developed the habits of good citizens.

The probation officer had assistance from the general secretary of the YMCA, who organized the boys into the "Squad Car Gang," one of the first Y-Gangs; the parish priest; elementary and high-school principals; the truant officer; police officers; individuals residing in the area; a juvenile-court judge; and a variety of solid citizens.

THE ELDEST CHILD. Edith G. Neisser. Harper & Bros., New York. 1957. 174 pp. $3.50.

This book, addressed to parents, analyzes a number of problems facing the oldest child in a family, such as his feelings when a second child is born and the responsibilities put on him for taking care of the younger children. The book also points out difficulties that occur when the eldest is an adopted child and subsequent children are born to the parents; when he is a stepchild; when death or divorce takes a parent out of the home and the eldest tries to take the place of the lost father or mother; also when the second child becomes the pseudo-eldest after the eldest dies.

# GUIDES AND REPORTS

YOUTH AND CRIME: Proceedings of the Law Enforcement Institute held at New York University. Edited by Frank J. Cohen. International Universities Press. 1957. 273 pp. $6.

The law-enforcement institute held in New York City in 1955, whose proceedings are reported in this book, was the first of three regional institutes planned by New York State authorities in cooperation with New York University to offer training to law-enforcement officers in dealing with juvenile delinquency. It includes papers from more than 20 specialists in various fields such as sociology; courts, including probation; psychiatry; corrections; criminology; police; public administration; and social work.

REPORT OF NATIONAL AGENCIES ON CHILD PROTECTIVE SERVICES: a statement on protective services for children. The American Humane Association, Children's Division, 896 Pennsylvania Street, Denver 3, Colo. 1957. 15 cents. Quantity discounts.

Reports highlights of seven workshop sessions participated in by representatives of the Child Welfare League of America, National Council of Juvenile Court Judges, National Probation and Parole Association, United Community Funds and Councils of America, U. S. Children's Bureau, and Children's Division of American Humane Association.

BLINDNESS IN CHILDREN. Miriam Norris, Patricia J. Spaulding, and Fern H. Brodie. Preface by Ward C. Halstead. University of Chicago Press, Chicago, Ill. 1957. 173 pp. $3.

The full report of a study of the development of blind preschool children made under the auspices of the University of Chicago clinics and reported on briefly by Miss Norris in the July–August 1956 issue of CHILDREN. It concludes that the adaptability of the blind child depends more on whether he has favorable opportunities for learning than on his degree of blindness, his intelligence, or the socio-economic or educational background of his parents.

DISCIPLINE. Association for Childhood Education International, 1200 15th Street NW., Washington 5, D. C. Bulletin 99. 36 pp. 75 cents.

A symposium on ways of achieving "self-discipline" in children. Addressed to parents and teachers.

YOUNG FOLKS IN HOMES; leisure-time activities in child-caring institutions. New York State Department of Social Welfare, 112 State Street, Albany, N. Y. 1957. 94 pp. Available on request from the New York department.

A guide to play activities for children at different age levels with reference to the special problems and opportunities inherent in an institutional setting. It discusses indoor and outdoor facilities, various types of activities, and leadership.

SOCIAL SERVICES FOR UNMARRIED PARENTS. Canadian Welfare Council, 55 Parkdale Avenue, Ottawa 3, Canada. 1957. 29 pp. 50 cents.

Discusses services needed by the unmarried mother and the putative father, and refers briefly to psychological factors that lead to unmarried parenthood.

PERSONALITY FACTORS IN MOTHERS OF EXCESSIVELY CRYING (COLICKY) INFANTS. Martin Lakin. Monographs of the Society for Research in Child Development, Vol. 22, Serial No. 64, No. 1. Child Development Publications, Purdue University, Lafayette, Ind. 1957. 48 pp. $1.75.

Compares mothers of 20 colicky infants with an equal number of mothers of normal, well-adjusted infants, as selected by pediatricians, and finds that infantile colic may be associated at least in part with tensions in the mother due to such personality factors in the mother as competitiveness with her own mother, mixed feelings about her role as wife and mother, inadequate marital adjustment, and uncertainty in carrying out mothering activities.

THE EXCEPTIONAL CHILD AND HIS PARENTS: a summer workshop, 1957. Arizona State College, Tempe, Ariz. 108 pp. $3.50 plus 25 cents for mailing.

Presents material used at a workshop for elementary- and high-school teachers on various types of exceptional children—the mentally retarded; the orthopedically handicapped; the epileptic; the child with reading disabilities; the child with problems of sight, hearing, or speech; the emotionally maladjusted; and the child from another culture; as well as the gifted child.

CAMPING GUIDE FOR THE PLACEMENT OF HANDICAPPED CHILDREN IN REGULAR CAMPS. Community Council of Greater New York, 44 East 23d Street, New York 10, N. Y. 1957. 33 pp. $1.

Describes camp programs, physical facilities, standards for staff, referral procedures, content, fees, and intake policies, as well as material on the values of integrated camping for both the handicapped and the nonhandicapped. Includes also descriptive material on various handicapping conditions in relation to camping.

PROCEEDINGS OF CONFERENCE ON RECREATION FOR CHILDREN WITH HANDICAPS. Baltimore Council of Social Agencies. 1957. 15 pp. Free on request from the Council.

Includes summaries of six workshops on the recreational needs and opportunities for handicapped children with recommendations for: a public-education program in this regard, with emphasis on the schools; coordination of agency efforts including the training of staff to work toward the participation of handicapped children in recreation programs; employment by the public recreation department of a specialist in work with the handicapped.

# IN THE JOURNALS

## *Speech Defects*

Children do not outgrow speech defects; on the contrary such defects become more set in the child's habitual speech pattern, says Irwin Lehrhoff in the January 1958 issue of the *Journal of Pediatrics.* ("Speech Problems in Children.") The pediatrician must use his judgment in referring children with speech difficulties for special help, the author says, but in general a child should get this help long before he goes to school, where deviant speech brings ridicule and teasing and leads to emotional problems that could have been avoided.

Before a child is referred to a speech therapist, he may need to be examined by a medical specialist such as an otolaryngologist, the author says, but he also points out that some children can be helped at an early age without special treatment if the pediatrician shows the parents how to provide a better speech environment. Furthermore, he adds, "Most speech disorders could probably be prevented if children did not have to learn the most difficult of all human coordinations with little help and much interference."

## *Parents and School*

Parents who have a child in a class for the severely retarded should recognize that the school is not attempting to make him normal but is helping him to grow up within his own limitations, says I. Ignacy Goldberg, in *Children Limited* for December 1957. ("Report on Trainables.")

After a year spent in 27 States, visiting schools for the severely retarded and participating in conferences, workshops, college courses, and parent meetings, in which more than 10,000 persons took part, the author reports his belief that the mentally retarded can be helped in school but that parents need to work more closely with the teacher. Helping the severely retarded child is a 24-hour-a-day job, 365 days a year, says the author. For doing this job, he adds, we need not only trained teachers but trained parents, and he urges parents to seek counseling for themselves so that they can better help their child.

Pointing out that the teacher of the severely retarded child is helping to increase his attention span, to improve his communication skills, and to develop his sensory abilities, the author urges parents to refrain from insisting that their child be given more academic work.

## *Adoption Controversy*

Should a social agency accept for adoptive placement the child of married parents? A casework supervisor discusses this question in *Child Welfare* for January 1958. ("Today's Controversial Clients: Married Parents Who Place Legitimate Children for Adoption" by H. Gordon MacKay.)

The author quotes figures showing that in 1953 one-eighth of the children adopted were born in wedlock and before adoption had both parents living together.

Summarizing information received last year from a number of adoption agencies, the author states that some agencies reported that they would not accept such children and told of "violent community reaction" to agencies that accepted them; some others had not set a policy, but seemed to be seeking a conscientious way of handling the problem. The most usual pattern among the agencies when a married couple requested adoptive placement for their child was to refer the parents to a family counseling agency, a policy with which the author does not agree. Instead, he says, the adoption agency caseworker should be prepared to offer them professional service.

Years ago, the author recalls, communities and agencies faced the same kind of controversy concerning placement of children born out of wedlock that they face today with regard to children of married parents. He maintains that since the request for adoptive placement for their child on the part of a married couple is an indication of emotional instability in a family it is therefore a sign that both parents and child need the agency's help "which may or may not lead to ultimate adoptive placement of the child." In instances where it does lead to adoption, he says, if the parents can be helped to feel they are giving their child a chance rather than a sense of rejection, the child may later have a sense of having been the subject of concerned planning rather than having been "thrown away" or "left on a doorstep."

## *For the Mentally Retarded*

The year 1958 promises to continue the 1957 advances in education for mentally retarded and other exceptional children, says Romaine P. Mackie in *School Life* for January 1958. ("Exceptional Years for Exceptional Children.")

The author, who is chief of the Office of Education's section on services for exceptional children and youth, reports that in 1957 major progress was made toward extending school programs to more children in exceptional groups, acquiring more knowledge about such children, and obtaining more and better-qualified personnel to teach them and to lead in preparing teachers for them.

Among the advances made in 1957, cited in the article, were mounting school enrollments in special education, studies of the problem of educating the rural handicapped child, multi-State activities to improve special education, and renewed efforts to coordinate the work of national organizations concerned with various types of exceptional children.

The author notes that 46 studies of the education of the mentally retarded, financed by grants from the Office of Education from funds earmarked by Congress for this purpose, are now being carried on by State education agencies and colleges and universities. Some of these studies are to be completed in 1958, she reports.

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# READERS' EXCHANGE

## GROSSER: *A place for all*

As George Grosser says in his article, the sociological point of view in institutional treatment has been neglected for too long. ("The Role of Informal Inmate Groups in Change of Values," CHILDREN, January-February 1958.) There is one point, however, that ought to be considered. Dr. Grosser is a sociologist and sees the problem from this frame of reference.

True, although we who administer training schools have accepted the philosophy of individualization and have done all we can to get sufficient staff in quantity and quality to do this job, and although no public institution has been able to achieve staff goals, we have placed too much emphasis on treating the individual alone, apart from the group. There is more need for group interaction, whether in group therapy, group activity, or task-orienting groups, on both the formal and informal levels.

We all want to change the values of boys committed to us, but how to change values and how to measure these changes present real problems. If a boy meets our expectations in behavior and also our social worker's belief that he is ready for release, do we have any assurance that his basic sense of values has changed? I don't believe we have any acceptable measuring device.

The problems presented are complex. Not all delinquency is group behavior. It is not entirely a social phenomenon. Children do act independently, just as some act through organized and unorganized groups. Some children are neurotic, some pre-psychotic, some psychopathic. Some come from repressive homes, others from homes where they have been rejected and neglected. Some boys will be overinhibited, some asocial, others, pseudosocial or gang oriented. We have found that no one skill can help any youngster. He requires the help of many skills, both lay and professional.

Psychiatry, social work, and the other professions have a place in treatment. The sociologists have a place in treatment. The lay person has a place in treatment. The community has a place in treatment.

Dr. Grosser does not mention the involuntary groupings found within our institutions. Boys classify other boys and place them in groupings that are not willingly accepted by the boys so placed.

Much that Dr. Grosser has to say is meaningful and practical. "Task orientation" of the informal groupings is an excellent suggestion . . . but let's still retain a place for those skills supplied through our individual therapists. There is room for all to be of help.

*A. Alfred Cohen*
*Superintendent, New York State Training School for Boys, Warwick, N. Y.*

### *Examples needed*

It is difficult to understand why, with such emphasis as presently prevails in the behavorial sciences to make constructive use of group dynamics, so little has been written as to the use of this potential in the training-school field. Dr. Grosser's article is a step forward in presenting some hypotheses in this area.

Our very social system revolves around intricate group patterns. Children identified as delinquents especially require the acceptance and security that a group provides, and as individuals they quickly assume the value system of the group of which they are a part. They will fight tenaciously against any attempt at dissolution of their informal groupings.

I could not help but feel that the five mechanisms of group control and maintenance which Dr. Grosser says are utilized by informal groups in institutions are also used to a large extent by groups of normal adolescents in normal communities. One would merely need to substitute for the term "administration," "parents," or "school authorities," or, at times, "society" itself. A recognition of these mechanisms and countless other methods of maintaining group control increases awareness of the need to help the groups to establish value systems which are socially acceptable.

In his article Dr. Grosser has barely touched on ways of doing this in an institution containing delinquent and emotionally disturbed children.

From my own experiences and observations in the training-school field, I would say that much has already been done toward carrying out his theories. Many schools are developing task-oriented programs built around the needs of the group. The process of group rewards as well as individual rewards has long been utilized. The use of existing group leadership to foster change within the group has been a well-recognized principle.

Dr. Grosser's final suggestion that group therapy or guided group interaction be attempted, using the informal groups as a base of selection, holds great promise. This procedure has been followed experimentally during the past year at the Fricot Ranch School with a high degree of success. However, when we gave free choice to our boys as to what group-therapy unit they wished to join, in most instances their selection was made on the basis of an identification with a participating staff member rather than with membership of an existing peer group!

Hypotheses, such as those suggested by Dr. Grosser, should be and are being tested, but there is a void of material as to results.

*Allen F. Breed*
*Superintendent, Fricot Ranch School for Boys, San Andreas, Calif.*

## GOLDFARB AND MANKO: *Homemakers and caseworkers*

I am impressed with the mutual respect and understanding shown by the workers of the family agency and the hospital social-service department in the article by Dora Goldfarb and Phyllis Manko. (See "Homemaker Service in a Medical Setting," CHILDREN, November-December 1957).

The case described is a good illustration of the three-way interaction involved in a complicated homemaker case. It was necessary for the caseworker to work closely with the homemaker and also with Mrs. X. before the two—homemaker and client—could respect each other and work closely together themselves.

In this case the careful and sound diagnostic assessment before a homemaker was placed in the home and throughout the contact was the secret of success. In many cases where the mother is suffering from a chronic illness it takes a high degree of skill to recognize the point of termination for the homemaker service, since it can become confused with household help. One safeguard is to set, more or less automatically, a time limit.

I agree with the authors that the question of fees from a family with high medical expenses needs "further experience." One method which we in this agency are trying is to have a member of the family sign an agreement to make monthly payments within the family's ability for a 6 months' period following the removal of the homemaker.

All communities with homemaker services do not have highly skilled caseworkers to help emotionally ill mothers remain at home with the help of a homemaker. However, there are many persons with physical illness whose families can be helped to stay together, or in which pressures on older children can be lessened through some help with household chores and child care. We have to face up to the fact that there is an overall shortage of caseworkers. Some communities have adapted to this by operating homemaker service programs effectively with the various degrees of casework skill available.

*Frances Preston*
*Director, Homemaker Services Unit, Family Service Association of Cleveland*

### TARJAN: *Community Rejection*

In his letter to the editor, Dr. George Tarjan seems to ascribe the failure of "every health, educational, social, or other community resource [to include] services and facilities for the retarded" to the "present shortage of qualified personnel". (Hormuth: "Trained Personnel Needed," *Readers' Exchange.* CHILDREN, November–December 1957.)

This may be one reason, but our experience has been that the major reason is the rejection of the problem by the community, reflected very frequently in our "health, educational, social, or other community resources."

Although I agree that it is imperative that specialized personnel be trained, the difficulty in obtaining such personnel is merely an excuse for not including the retarded in a service. Not only must we train specialized personnel, but we must educate all disciplines to understand the value of the retarded as an individual and his, at the very least, moral claim on the professionals and community agencies.

Dr. Tarjan suggested that it is necessary to know how many clinics are needed as a prerequisite for a program. The American Association on Mental Deficiency has said that one clinic per 150,000 population is needed. On the basis that 3 percent of the population is so mentally retarded as to need special services, I think this is a pretty good jumping-off point.

*Joseph T. Weingold*
*Executive Director, Association for the Help of Retarded Children, Inc., New York.*

### STUDT: *Goals must be correlated*

The framework which Dr. Studt developed for the understanding and classification of hard-to-reach groups is a major contribution to those of us who are trying to identify and serve such groups. (See "The Nature of Hard-to-Reach Groups," CHILDREN, November–December 1957.)

However, my major concern about the six dimensions of group life which Dr. Studt has identified is that group workers may become so preoccupied with the classification of various groups that they may overlook the differences among individuals which exist within any one of them. I am sure that such was not Dr. Studt's intention and, in fact, her very first admonition is that "we should be clear about the kinds of individuals in the group membership" and "the motivations of the individual members for participating in the group." As we utilize Dr. Studt's tools to increase our total understanding of a particular hard-to-reach group, our concept of working with such a group may change. Because intensive service can reach but a small segment of the gang in any case, some of us may conclude that social groupwork can be most effective if offered only to those members of the total group who have similar motivations for identifying with it. If we were to decide to provide social groupwork service to the self-identified delinquents, this smaller group could become the milieu through which these individuals could find acceptance of themselves and become involved in the slow process of change.

I cannot accept the hypothesis that the group may not be an effective tool for "reaching and influencing young persons who are strongly self-identified as delinquents." Rather than deemphasizing the value of the group in the treatment of such youth, I think group workers are called upon to consider modifications in their concepts of group life and in the use the members make of the group. As we are able to relate *our* goals for the group and its members to the group's *own* conscious and unconscious goals, we are likely to find that although these groups are difficult to serve they may not be hard to reach. This process of the correlation of goals based on our knowledge of the nature of the groups we serve may require an administrative rethinking of agency function and purpose.

*Margaret H. Mudgett*
*Executive Director, Neighborhood Youth Association, Los Angeles.*

### CORRECTION

I was naturally pleased that my article, "Analyzing a Statewide Adoption Agency's Statistics," printed in the November 1957 issue of *Child Welfare* had been considered worthy of review. (*In the Journals*, CHILDREN, January–February 1958.)

I feel some concern, however, over one inaccuracy on the part of the reviewer in quoting statistics which affect the statewide picture in Washington. The review says: "The author also quotes figures from the State public welfare agency showing that between 1950 and 1956 the percentage of independent adoptions by persons unrelated to the child decreased from more than half to less than one-fifth."

We could wish that the situation were this bright, but it is not. If the fourth paragraph of the original article had been correctely interpreted, the review would have stated that the percentage of independent adoptions by persons unrelated to the child decreased from 64 percent to 42 percent between 1950 and 1956. The original material stated that in 1950, 36 percent of the reported adoptions were of children who had been placed by approved social agencies; that in 1956, 58.2 percent had been so placed.

*Elizabeth T. Bannister*
*Assistant State Director, Washington Children's Home Society, Seattle*

## SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

**Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order. Twenty-five percent discount on quantities of 100 or more.**

RESEARCH RELATING TO CHILDREN, March 1–July 31, 1957. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1957. 142 pp. $1.

This latest compilation of reports of ongoing research in fields concerning children includes research programs in physical and motor development, intelligence, behavior and personality, education, health services, and social services. Reports on pediatric research are limited to studies of interest to investigators outside the medical field.

SCHOOL HEALTH SERVICES; a selective review of evaluative studies. Bronson Price. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1957. 149 pp. Price 45 cents.

Some 300 studies of the effectiveness of elementary-school health programs are reviewed in this pamphlet. The studies are grouped according to the basis for evaluation: (1) rates of children's illnesses, deaths, accidents, and so forth; (2) survey findings; (3) the judgment of experts; (4) reexamination of the children; and (5) the use of controlled experiments. Suggestions for the design of future studies are included.

COST OF SERVICES TO CRIPPLED CHILDREN; a study of nine State programs. Lillian R. Freedman. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 43. 1957. 27 pp. Copies available from the Children's Bureau without charge.

Presents data collected through a pilot study made to explore the feasibility and usefulness of recording and analyzing the kind, amount, and cost of service for a particular child. Most of the tabulations cover direct expenditures for the care of individual children, classified by diagnosis and by type and volume of service. In addition, data from 6 of the 9 States participating are given, covering direct expenditures not allocated to individual children, such as the annual salary of a staff physical therapist and other costs in operating the crippled children's program.

DOMESTIC AGRICULTURAL MIGRANTS IN THE UNITED STATES; counties estimated to have 100 or more at peak of normal crop season. Department of Health, Education, and Welfare, Public Health Service and Children's Bureau. PHS Publication No. 540. 1957. Chart, 10 by 13 inches. 25 cents. Single copies are available without charge from the Public Health Service and the Children's Bureau.

Prepared as a basis for planning health services, the map reproduced on one side of this chart indicates the peak demand in 902 counties for domestic agricultural workers from outside the country. The other side gives the population of these counties, and the estimated number of migrants needed by each. These basic data were obtained from the U. S. Department of Labor and Agriculture and were checked by State health agencies.

GROUP LEADERSHIP IN STAFF TRAINING. Eileen A. Blackey. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance and Children's Bureau. BPA Publication No. 26; CB Publication No. 361. 1957. 182 pp. 55 cents.

Based on data collected from supervisors and training consultants in public welfare agencies, this report discusses the group process and its influence on learning and offers guidance to leaders in staff-development programs.

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Tender loving care is the magic formula used by this nurse in Metera, a new children's institution in Greece for the temporary care of children awaiting adoption or foster-home placement. Each "mother-nurse" cares for no more than four children in order to have time to attend to their emotional as well as material needs. The possibilities of helping children in institutions throughout the world are soon to be explored by the United Nations Children's Fund (UNICEF). (See page 114.)

## ◀ *the authors*

For the past 7 years Eleanor Maccoby has been participating in Harvard's researches in child development and lecturing to Harvard and Radcliffe students in the university's Department of Social Relations. She was formerly study director for the Division of Program Studies, Department of Agriculture, and for the Survey Research Center at the University of Michigan, where she received her doctorate. She is coauthor of "Patterns of Child Rearing," by Sears, Maccoby and Levin, Row-Peterson 1957.

The project for training nurses to lead parent-education groups Aline Auerbach describes is one of a series for various professional groups she directs for the Child Study Association. Other projects have focused on caseworkers, groupworkers, community organizers, educators of various types, and clergymen. A graduate of Barnard College with graduate study at Columbia University's Teachers College and New York School of Social Work, Mrs. Auerbach has worked extensively with parents, individually and in groups.

Before going to her present position in 1955, Wilma Gurney was successively with the Fresno County (Calif.) Department of Public Welfare as supervisor of child-welfare services, the International Institute of Fresno, and the Hospital Social Service Department of the American Red Cross. She has a master's degree in groupwork and recreation from Ohio State University and another in social welfare from the University of California at Los Angeles. She has taught undergraduate social-work courses at Fresno State College.

A New Zealander by birth, Harben Boutourline Young took his medical degree at the University of London. After wartime service with the British army and a residency in pediatrics in London, he came to the United States to become research associate at the Boston Lying-In Hospital. In 1950 he joined the staff of the Department of Physiology, Harvard School of Public Health. Since 1952 he has been directing the Harvard study of Italian boys described in his article.

Prior to coming to the Children's Bureau a year ago Michael J. Begab directed social services at the diagnostic center of the State school for mentally retarded at Columbus Ohio. Previously he served in a similar capacity at Ohio's institution for the criminally insane at Lima. A graduate of the School of Social Service Administration, University of Chicago, he has also worked with mentally retarded children in Wisconsin and with emotionally disturbed blind persons in Illinois.

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# CHILDREN AND WORKING MOTHERS

ELEANOR E. MACCOBY, Ph. D.
*Staff member, Laboratory of Human Development, Graduate School of Education, Harvard University*

INCREASINGLY, women with young children are taking jobs which take them away from their households during the day. What are the effects upon their children? Must we expect repercussions in the children's emotional, intellectual, or moral development? Is there any relationship between maternal employment and the incidence of juvenile delinquency or school-adjustment problems? Or does the mother's working stimulate the child, by example, to a greater interest in job achievement?

Actually, the fact that his mother works outside the home is but one of many factors bearing upon a child's development. We know little about its importance in relation to such other factors as the child's inherited intellectual and physical capacities, his parents' emotional stability, the type of community in which he is being raised, and the size and composition of his family. The effects of the single factor, *maternal employment*, if any, may be small, and they will not be the same on all children. What happens to the child will depend upon the effects of other factors interacting with the effects of the mother's absence from the home.

### *Juvenile Delinquency*

A positive relation has been widely assumed between mothers' working and juvenile delinquency. Studies of groups of juvenile delinquents often show that a higher proportion of their mothers work than the mothers of children in the population at large. However, most juvenile delinquents come from a stratum of society in which a mother's employment is likely to be an economic necessity. Possibly, at this economic level, an equally large proportion of mothers of children who have *not* become delinquent work.

In their study of 500 delinquent boys Sheldon and Eleanor Glueck provided a research control of such factors as economic level [1] by comparing the delinquent boys with a group of nondelinquents who were like them in intelligence, ethnic background, and age, and in the fact that they lived in underprivileged neighborhoods. The proportion of mothers who worked *regularly* outside the home was no different for the two groups. But the group of delinquent boys contained a larger proportion whose mothers worked *sporadically.*

On the surface this might suggest that if a mother wishes to work at all, she ought to work full time. But it may not be the sporadic absences which create adjustment problems for the children, but something about the family characteristics which led both to the mother's sporadic employment and her child's delinquency.

What were these "occasionally employed" mothers like? Many of them were women who had a history of delinquency themselves, and many were married to men who were emotionally disturbed and who had poor work habits. Commonly, the husband and wife were incompatible and each lacked self-respect. It is doubtful, therefore, whether the mothers' sporadic employment *as such* was conducive to delinquency in the sons; more probably the emotionally disturbed and antisocial characteristics of the parents

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Based on a paper prepared for the National Manpower Council's conference, "Work in the Lives of Married Women," October 1957.

produced the mother's sporadic work pattern and at the same time led to delinquent tendencies in the sons.

The Gluecks' study includes data revealing the importance of the kind of supervision a mother arranges for her children while she is away at work. The accompanying table presents a recomputation of the figures presented in table 3 of the Gluecks' article, "Working Mothers and Delinquency."[2]

According to this study, if the mother remains at home but does not keep track of her child, he is far more likely to become a delinquent than if he is closely watched. Furthermore, if a mother who works arranges adequate care for the child in her absence, he is no more likely to be delinquent than the adequately supervised child of a mother who does not work.

Another study of delinquency[3] compares a group of middle-class delinquent boys with boys similar in socio-economic status who were not delinquent. While both groups were small, and the differences between them in the rate of maternal employment were not statistically significant, there were, in fact, more non-delinquent than delinquent boys who had working mothers.

Middle-class mothers who go out to work are usually in a good position to arrange reliable care for their children.

### *Other Adjustment Problems*

A number of studies have shown some association between maternal employment and adjustment problems of children. Unfortunately, in these such factors as economic status and emotional stability of the parents have not been held constant. In one study a group of adolescent girls whose mothers worked full time were compared with a group whose mothers did not work.[4] In response to questionnaires, a greater percentage of those whose mothers worked than of the others indicated these problems:

1. An unwillingness to discuss their activities and their problems with their parents.

2. A feeling that their parents did not understand them when they *did* attempt to explain.

3. A feeling that their families did not have a "good time" together and that family meals were gloomy affairs.

4. Feelings of being rejected by their fathers and of shame at their fathers' behavior.

Since the two groups of girls were not matched according to economic level, we cannot tell whether the majority of the working mothers came from the low-income population, where child rearing is somewhat less permissive and more punitive than in middle-income groups,[5] and in which tension is more apt to exist between husbands and wives. Perhaps the attitudes of the daughters are a reflection of the interpersonal relationships in their homes.

**RELATION OF JUVENILE DELINQUENCY TO MATERNAL EMPLOYMENT AND QUALITY OF CHILD SUPERVISION**

| | Mother's employment status | | | | | |
|---|---|---|---|---|---|---|
| | Housewife | | Regularly employed | | Occasionally employed | |
| Supervision of child. | Good | Poor | Good | Poor | Good | Poor |
| Percent delinquent.. | 32 | 84 | 19 | 77 | 32 | 88 |
| Number of cases.... | 457 | 149 | 82 | 110 | 89 | 116 |

To obtain these percentages, the 2 groups of children studied by the Gluecks (496 delinquent boys and a matched group of 497 nondelinquent boys) were combined into 1 population which was then subdivided on the basis of maternal employment and the quality of supervision provided for the child.

Curiously enough the girls with working mothers seemed to have more disturbance in their relationship with their fathers than with their mothers. Possibly the mother's working in some way weakens the father's role in the family so that the daughter does not respect him as much as she might otherwise. An equally possible explanation, however, is that a number of the mothers are working because their husbands are unstable, a quality which might produce negative feelings toward a man on the part of both wife and daughter. Until we can compare families which are initially similar in paternal stability and economic level, we will not know the effect of the mother's working *per se* on adolescents' adjustment.

An interesting study on school adjustment problems[6] was based on a number of children referred to a school-district guidance department for a variety of reasons, including school failure, aggressiveness, excessive withdrawal, and stealing. In this school district the large majority of the children of working mothers and also of those of nonworking mothers had never been referred to the guidance office at all. Among the children who had been referred, however, the children of working mothers were somewhat different from the children of nonworking mothers. The former were younger, and proportionately fewer of them were referred for academic failure and more for withdrawal tendencies.

Thus we have some slight evidence that in the small group of cases where the mother's working may contribute to school maladjustment, it is likely to do so at the time when the child first enters school, and that the child is more likely to suffer from a difficulty in relating adequately to other people than he is from academic failure. However, we do not know whether it is the mother's working which is behind the problems that appear, or whether both the problems and the mother's working are reflections of some other factor.

We know very little about whether the fact that a mother works stimulates her children to vocational achievement. Probably, much depends upon the nature and status of the mother's work. Perhaps the example of the mother's serious interest in outside work makes her children regard work highly. We do know that many men of achievement have had mothers who had flourishing careers or were otherwise active outside the home. We also know that high achievement motivation in children is often associated with the early application of parental pressure for independence.[7]

If mothers who work take special pains to train their children to do things by themselves, then their children might be expected to be especially self-reliant. However, if employment leads a woman to devalue her husband, then her son may be in conflict about the acceptability of maleness and may eventually find it difficult to succeed. Since we have no evidence for singling out the effect of a mother's working on her children's achievement, we can only suspect that much depends upon what the mother's motivation for working is.

## *Behavior Training*

At all stages of their development, children require detailed training in major and minor skills as well as in moral standards.

Does a mother's working affect the quality and effectiveness of the training a child receives?

Child training is made up of thousands of episodes during which an adult caretaker distracts a child from undesired activity, interests him in desired activity, physically stops or prevents him from certain actions, guides his early attempts to acquire a skill, punishes or rewards a spontaneous action, or "reasons" with the child by making clear the possible consequences of certain actions.

What determines the effectiveness of these efforts? First, the trainer must *be there* when significant events occur, to reward, punish, or explain. The bedtime comment, "You've been very good today," will please the child, but it will not help him to differentiate approved from disapproved actions. Second, the child learns more easily if the caretaker is consistent in her demands and reactions. Third, the caretaker's effectiveness depends in part upon the nature of her disciplinary measures. And finally, discipline is apt to be more effective if administered by a person with a nurturing relationship to the child.

The theory behind this last point runs as follows: punishment emanating from an individual whom the child does not love leads to fear on the part of the child and resultant efforts to escape or to conceal misdeeds. Punishment from a loved person, however, creates a different kind of problem for him: he wants the approval of the disciplinarian, and he cannot get it by running away, but only by conforming to her demands, by confessing and being forgiven, or by repairing the damage he has done. Ultimately, discipline administered by a loved person is more conducive to the child's internal acceptance of the values being taught him so that they become his own.

Experiments growing out of this theory have been done with animals.[8 9] There is already some evidence for the following conclusion: When one attempts to train a dog to "resist temptation," the training is more effective if the person who administers it has previously had a nurturing relationship to the animal in puppyhood. Punishment by a stranger, or a person who has acted coldly or restrictively toward the dog as a puppy, does not so often produce the desired results.

If such experiments have relevance for humans, they would seem to indicate that the effectiveness of discipline administered to the child of a working mother depends upon the total relationship of the child with his disciplinarian. If his nurturing is divided between two people at different hours then discipline should be similarly divided. It would seem unwise for a mother to try to "make up" to the child for her absence by being so indulgent while she is with him that she does not exercise disciplinary control. Equally unwise would be a policy of delegating caretaking but not disciplinary functions to her substitute.

A primary consideration, therefore, is whether there *is* an individual who assumes full responsibility for training the child in the mother's absence. Among delinquent children are many whose mothers have not arranged for such care, leaving them to roam the neighborhood unchecked after school hours. We can assume, however, that most working mothers try to arrange for some kind of substitute care.

What kind of substitute care is adequate from the standpoint of child training?

If the mothers remained at home they would vary widely in their training efforts. Some mothers do so much warning, explaining, guiding, and rewarding that their children become "overcontrolled," passive, and lacking in initiative. Other mothers interact with their children very little except when an emergency arises. A caretaker substituting for an overcontrolling mother would be unlikely to exercise as much control, unless she is a relative with similar traditions. On the other hand, a caretaker substituting for an aloof mother is apt to expend at least as much effort in child training.

In any case, the adequacy of the substitute caretaker depends not so much on the *amount* of control she exercises nor on *how* she does it, but on *how similar* her reactions are to those of the mother. For very young children a standard routine, even in minor matters, brings comfort and security. If the mother and her substitute adhere closely to the same routine and react similarly to the child's actions his learning task is simplified and his feelings of security enhanced.

As a child grows older he can begin to discriminate between what is expected by one person and what by another, and can adjust his behavior accordingly. By the age of 4 or 5 he can profit by beginning to have some experience in adjusting to the idiosyncrasies of different caretakers. Such experiences can prevent him from becoming rigid.

## *Ratio to Adults*

Another important consideration is the number of children being cared for by one person. Many children of working mothers are left in day-care centers where the ratio of children to adults is high. In these the adults are usually so busy feeding the children, cleaning up, setting out play materials, and supervising group activities, that they have little time for individuals except when signs of trouble occur, and not always then.

In such settings, the children sometimes take over disciplinary functions, and scold or hit one another in an attempt to stop antisocial behavior.[10]

However, such reprisals are probably not as effective as those administered by adults. Moreover, the sanctions wielded by a child's peers do not always serve the values of adults.

**The obvious warmth of this day-care-center teacher attracts these children like a magnet. Children lonely for their mothers often comfort themselves by clinging to a staff member. In the beginning some seek constant attention.**

Group care, however, has some positive features. Often the persons in charge of children's groups are better trained, more patient, and more objective in dealing with the children than the mothers. A child can be allowed greater freedom to run, climb, and throw in a nursery school than in a home full of breakable objects. This greater freedom is reflected in the more rapid development of motor coordination in children in group care during the second year of life. But their lower level of individual interaction with adults is reflected in slower language development and toilet training.

True, these findings come from studies of children who have lived in groups almost exclusively and not of children who have spent about 40 hours per week in a group and the rest of their time with their families, as do children in day-care centers. It seems reasonable to conclude, however, that if the children of working mothers are cared for in groups during the day, certain features of behavior training may not proceed as smoothly as they might with individual care; but that they may derive some benefits from the experience of sharing with other children, and some stimulation from the variety of playmates, the freedom of movement, and the caretaker's skill.

Is the kind and duration of separation involved in a mother's working sufficient to produce trauma in a child?

From the work of such pioneering researchers as René Spitz,[11] John Bowlby,[12] Anna Freud,[10, 13] and W. Goldfarb[14] we know that:

1. Some young children, when separated from their parents for a week or longer go into a depressed, withdrawn, apathetic state from which it is difficult to rouse them. When they are reunited with their parents they do not recover at once from their grief, but become excessively "clingy" and suffer sleep disturbance.

2. Children vary greatly in their vulnerability to separation trauma.

3. Very young infants show few effects from separation. Children between 1 and 3 years are most vulnerable. Older children can begin to understand a little about the reasons for the separation and can be comforted by a promise that it will not last long.

4. While the most severe effects have resulted from separations lasting for a week or longer, many young children show disturbance of a lesser degree on very brief separation, such as when their parents leave them with a sitter for an evening. Commonly, however, such disturbance disappears shortly after the parents are out of sight.

Lasting damage to the child has been alleged to have been brought about by long-continued "maternal deprivation," especially among children institutionalized for the first years of life.[14] However, the child of a working mother does not usually suffer this degree of maternal deprivation, if any. He has the attention and love of his mother during a predictable portion of his waking hours, and in her absence he has the attention, and perhaps love, of her substitute. Unless he is cared for in a large group during the day and neglected grossly by his mother in the evening, he would not be likely to undergo the kind of deterioration observed among institutional children.

The problem for children of working mothers seems to lie in the area of separation anxiety. Is the child made anxious each day when his mother goes off to work? Does he feel rejected, abandoned? If so, are there lasting effects? We actually know very little about these questions, though we can point to a few relevant observations.

In Okinawa, the mother of a young child customarily goes to work in the fields during the day. In her absence, the baby is cared for by a grandmother or an adolescent girl until school is out. Then a girl between the ages of 6 and 12 puts the baby on her back, in a sling, and carries him there through all of her afterschool activities until the mother returns home from the fields.

Okinawan babies seldom cry when their parents go off to work in the morning, but they *are* upset by "back-weaning" by being told that they are too old to be carried about constantly any more.

This example suggests that young children can easily adjust to caretaking divided between the mother and some regular substitute. It also suggests that perhaps the child's adjustment is made easier: (*a*) if this division of responsibility is a common practice; (*b*) if the mother's daily departure is begun in the child's infancy, rather than after the child has become accustomed to a single caretaker; and (*c*) if the substitute has child-care techniques like those of the mother.

Perhaps if the child is cared for by a number of familiar adults the affectional relationship between mother and child will be less intense—as it is in large families where the child interacts with his brothers and sisters more than with his parents. Such attenuation of the mother-child relationship may not necessarily be harmful, but it probably produces a different kind of personality than an exclusive mother-child relationship.

A study in England compared observations of two groups of 2-year-old children during 3-week periods; one group temporarily staying in a residential nursery, and one group in a day-care nursery.[15]

Some of the findings were:

1. On their first day in the nursery, both groups of children cried a lot for their parents. As time progressed, however, this type of crying practically disappeared among the day-nursery children, who were satisfied to ask about their parents in order to be assured that they were coming back. The children in residence, however, continued to cry frequently for their parents.

2. The day-nursery children sought substitute attention in a matter-of-fact way (such as attempting to be near the observer) while the residential children sought direct evidences of affection, such as insisting on being held, and accompanied their seeking by crying.

3. The residential children showed increasing signs of severe hostility. The day-care children expressed a normal amount of hostility.

4. The day-care children continued to be eager to see their parents at the end of the day. The residential children cried when their parents visited and some failed to recognize their parents.

These findings suggest that, while there is an initial disturbance for the young child when a working mother first leaves him with a substitute caretaker for part of the day, he adjusts quickly to the new routine and appears able to maintain a close affectional relationship with his mother. Long separations, however, are much more disturbing and the disturbances may continue beyond the time when the child is reunited with his family.

### *Identification*

On the other hand, there may also be danger in *not* separating mother and child often enough or early enough. It is possible for the dependency bond to become too strong, particularly if the mother has certain neurotic needs that she works out through a "smothering" attachment to the child.[16] A cross-cultural study of male initiation ceremonies at puberty has indicated that a too-strong dependency bond between mother and child may generate certain strains which require the family to undergo great stress in the process of the child's achieving independence.[17] If a mother works away from home, the process of gradually loosening her children's dependency bonds may be simplified.

Much of what an individual becomes, according to psychoanalytic theory, derives from the degree of success with which he can, in early childhood, pattern himself upon his parents. Does a mother's working interfere with the orderly development of identification, and if so, with what consequences?

Any discussion of the relationship of maternal employment to a child's ability to "identify" with parental figures must proceed on shaky grounds. Students of the topic have reached no generally agreed upon definition of the concept, "identification," and have only begun attempts at its measurement for research purposes.

We can, however, assume that one way in which children build up values and develop styles of behavior is by patterning themselves on a model. Although psychoanalytic theory has emphasized the importance of the same-sexed parent as such a model, the child can and does identify with more than one person, incorporating values and habits of behavior from a number of sources.

Though affection may be one of the prime factors stimulating identification, enough examples exist of a child's adopting the characteristics of a strong though cold or hostile figure in his life to indicate that *power* may be even more important than love in this regard. That is, the child will generally identify with the person or persons having closest control over his destiny.

How would the fact that a mother works be likely to affect her children's identification with her? The answer probably depends in part upon the mother's relationship with her substitute. If the mother delegates child care to a servant who clearly respects her authority, the child will probably identify more with the mother than with the servant as soon as he is able to perceive where the source of authority lies. On the other hand, if the mother leaves her child with a day-care-center teacher who thinks of herself as more expert about child rearing than the mother, the child will be likely to pattern himself on the teacher. If care is divided between equal-status relatives, the child will probably incorporate behavior patterns from each.

Anna Freud and Dorothy Burlingham report some instances in which they believe division of identifica-

This 3-year-old in a day-care center is surmounting the difficulties of shoe tying. Does the seriousness of his expression come from complete absorption in his task or does it reflect a bit of after-nap loneliness for his mother?

tion generated conflict in children of 2 and 3.[10] In one, a mother on periodic visits to her little girl in a residential nursery scolded her harshly. After these visits, the child would treat her doll in the same harsh manner, but as time passed, would revert to acting out in doll play the more patient care which was characteristic of the nursery "housemother."

The same kind of conflict arises, presumably, when a child's parents differ widely in their ways of reacting to him. However, incorporating divergent values may not always be worse for a child than incorporating a single set of values. In the example given, the child may have been better off with the conflict described than she would have been if she were exposed exclusively to her mother's harsh treatment.

For healthy development, children, especially boys, need a strong masculine model. We have already noted that disturbance in the father-child relationship sometimes coincides with the mother's working and that the mother's working itself may have resulted from a family-relationship disturbance.[2,4]

What effect would the mother's working be likely to have upon the children's ability to identify with their father?

On the one hand, the dilution of the relationship between the mother and the children brought about by the mother's daily absence from home gives the father an opportunity to interact with the children nearly as much as the mother. On the other hand, the very fact that the mother works may detract from the husband's status in the eyes of the children.

It does not necessarily follow that the mother becomes dominant, or that the father suffers loss of status when the wife works. Where a good relationship exists between husband and wife, neither parent need be devalued in the eyes of the children. Whether or not the mother works is less likely to determine her husband's stature as an identification model for the children than the amount and kind of interaction between the father and the children, his own self-esteem, and the wife's underlying attitude toward him.

Clearly no single way of organizing family life is best for all. Some mothers should work while others should not.

When the mother works, outcome for the children will depend upon many factors: the age of the children, the nature of the mother's motivation to work, the child-care skill of the mother and of her substitute, the composition of the family, the stability of the husband, and the pressure or absence of tension between the parents. We cannot yet specify just how these factors influence the impact upon children of the mother's working. The necessary factfinding has only just begun.

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*Group participation is stressed in training leaders for . . .*

# CLASSES FOR EXPECTANT PARENTS

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FOR SEVERAL YEARS the Child Study Association of America has been carrying on a series of experimental training programs for nursing personnel in leadership of parent and expectant-parent groups. With aid from the Children's Bureau, these programs have been conducted for nurses in the State health departments of New York and New Jersey.[1] They have especially emphasized one method, the use of group-developed discussion in conducting parent-education classes.

Many nurses find it difficult to develop participation as an important part of group learning, as the approach it requires is markedly different from the more traditional curriculum-centered approach, though the goals are in many ways the same. The differences lie first in the nature and scope of the subject matter discussed and second in the teaching method used.

Our groups for expectant parents meet for 6 to 8 sessions. Some are for mothers only; some for fathers only; and some for couples. As with traditional classes, their purpose is to give the members added understanding of the physical aspects of pregnancy and to prepare them for labor, delivery, and the care of the newborn. The distinctive addition is that in these groups the participants gain an understanding of the psychological and emotional reactions of themselves and their mates to the pregnancy and to the coming of the baby and look at the fears, fantasies, and expectations that often arise during this period, checking them as far as possible with reality.

In many meetings conducted in the traditional manner much of this "emotional" material is brought out, but usually not until the question period following the formal talk. Sometimes it is expressed around the edges of the meeting, being directed to the leader before or after the session or to other group members in undertones during the discussion or over coffee cups afterward. The difference in discussion groups of the kind we are describing is that the group members are not only allowed but encouraged to present what is on their minds for honest appraisal by and sharing with the other members. Thus the expression of ideas and feelings becomes a legitimate, important part of the content the expectant parents discuss along with the facts they also are seeking.

## *The Method*

The content of the meetings is not planned ahead in an outline or curriculum. It grows out of the group members' interests and concerns as revealed in their discussions. The material is developed through group discussion during the entire session and not merely in a question-and-answer period following a talk. The leader helps the members to share and balance their ideas, experiences, and anticipations, to focus the discussion, and to explore the topics from many different aspects, and then

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adds information which the parents do not have. The leader does not tell the group what she thinks they ought to know without first finding out: (1) the extent of the information they already have; (2) what it is they really want to know; (3) the level of their learning and of their ability to add to their understanding; and (4) their response to the particular topic under discussion. Since the teaching material is not prepared in advance, the teacher must have a fund of knowledge to draw on as the group presents topics for discussion.

It is part of the leader's responsibility to give the group at some point the opportunity to talk about questions which she knows from her professional experience expectant parents usually want to explore. If the participants themselves do not bring up these subjects, the leader suggests them, giving the group the freedom to discuss them as far as they like or not to discuss them at all.

We have found that when a leader has pointed such questions out to a group, the members usually have responded to her lead, though not always along the lines or with the same detail that she has expected. If, for example, a group has not discussed the sequence of labor and delivery by the fifth or sixth meeting, the nurse-leader *must* point out that as yet no one has expressed any interest in this part of the coming experience, an aspect which interests most groups of expectant parents. By thus encouraging the group to talk about the subject, she may indirectly help the parents to overcome a possible reluctance on their part (she does not, however, discuss this reluctance directly with them) and open the way for a helpful discussion.

If the participants do not follow her suggestion, the leader respects their decision, but thinks carefully about what may lie behind their hesitancy and how she may help them to overcome it. In practice we have not known any group of expectant parents to complete its sessions without some discussion of labor and delivery. All the other major areas of interest are usually also brought into the discussion, although they are not all pursued to the same extent or developed in the same way from group to group.

This brief description of the discussion-centered focus of group education for expectant parents indicates how this method differs from other kinds of group teaching. It differs from the more traditional, didactic approach in not concentrating on imparting a fixed body of information as outlined in a set curriculum. It differs from some other types of group discussions in making special use of the group process and group techniques in relation to one specific and important part of the participants' experience—their preparation for the birth of a new baby and for the resulting changes in their lives.

The nature of the subject matter calls for a kind of leadership skill that is different from that required for staff education, for social action or for other functions carried out through groups. The primary purpose is not to give the members a better understanding of one another (though, hopefully, this might be a secondary result) nor is it to come to agreement or consensus on the topic under discussion. The primary purpose is to help the participants to acquire a better understanding of the situation which has brought them to the group, so that each may be prepared for the new experience and better able to do what he or she feels is right.

## *Groundwork for Discussion*

Participation in this kind of group discussion is important, but not as an end in itself, as it is in certain types of group work which have a primary aim of improving each participant's performance as a group member. When the discussion is developed chiefly from the ideas contributed by the group, participation furnishes the clues to the members' interests and needs. It starts the discussion at these points and supplies the groundwork on which the members can build a wider range of information and a richer understanding of themselves and the situation they are facing.

Participation is also the path through which the group member channels and expresses his involvement with the subject matter and with the group. The expectant mother learns from the beginning that she can freely express whatever she is thinking or feeling—her doubts and uncertainties about herself, her need for information, her own and her husband's ideas about how long he will stay with her during labor, their ideas about "natural childbirth," their anxieties about their ability to take adequate care of the baby, or whatever else is on her mind. Each participant finds that he is being listened to and that he is playing an essential role in determining what the group will discuss, even though the leader's purpose is to effect a broadened understanding in the group as a whole about matters of common concern. Because they function actively the participants come to feel that the group is theirs.

Expectant parents come to these classes because they feel a strong personal need for a better understanding of what they face. They want more knowledge about all aspects of their approaching parenthood to help them go through labor, delivery, and the postpartum period with a minimum amount of fear and with confidence and competence. They become intensely absorbed in the discussions as they learn through experience how all the participants' needs are met, and especially their own. They talk about the fact that they look forward from week to week to see how the discussion develops, as if it were a continued story. They are a part of it, and behave quite differently from expectant parents who come to sit passively listening to a lecture which they can attend now or in six weeks time when the next course gets around to the same point.

### *The Leader's Considerations*

The foregoing should not be interpreted to mean that each person does or even should participate in the same way or to the same extent. The leader does not put any pressure on the group members to talk and is careful not to make them feel self-conscious about how much they participate in the group. However, the leader does try to encourage each person who is ready to speak out to do so and, at the same time, to help the too-active participants to learn to listen and to give the others a chance.

People learn at different speeds and in many different ways. Some expectant parents "participate" very little in the sense of talking. Yet they may be learning as much as the others by listening and by thinking things out. Their facial expressions and body postures often reveal the extent to which they are "with the group."

Building the subject matter from the expressed interests of the group members has many other advantages. It enables the participants to discuss what is really on their minds rather than what the leader thinks they should know. It keeps the discussion close to their real experiences, rather than off somewhere on a general, intellectualized plane. Yet this does not mean that the discussion will not reach some basic generalizations. Some discussions have started with such specific points as the discomfort of an expectant mother in her seventh month of pregnancy and have proceeded logically from the reasons for her feelings of physical pressure to a review of what has gone before in the growth of the baby, as well as to a look ahead at what is to come—thus producing a better understanding of the total birth process.

The leader must consider carefully what parents may really be asking when they introduce a subject for discussion. She needs to find out what they already know about the topic or what they have been thinking about it. This type of awareness accomplishes several objectives: (1) it keeps the leader from letting the talk go off on a false track; (2) it helps her to draw out the members' experiences so that she can sense what they already do know and not waste time by unnecessary repetition; (3) it gives her an idea of the degree of the group's readiness to move into the subject under discussion; and (4) it clarifies the concern that prompted the question or expression—not always evident at first.

Encouraging group participation is particularly effective in getting at "the question behind the question," which the questioners themselves may not have seen clearly. These underlying concerns come out best when the participants in the discussion have time and "room to move around in," as one nurse has said. The introduction of the topic of natural childbirth, for example, often seems like a simple factual opening. When it is explored further, it may reveal all manner of confusions as to what the term really means as well as anxieties about the experience of delivery itself and the mother's tolerance and fear of pain. Questions about formula preparation, important though they may be in showing the young expectant mother's need for practical information and help, may also be the indirect expression of conflict and confusion over the choice of breast or bottle feeding—a subject which the group needs to talk through from all points of view.

Gearing the discussion to the interests and readiness of the group, as revealed by the members' questions and remarks, tends to make the group experience more meaningful to the participants. Dr. Gerald Caplan [2] and other observers of the emotional and psychological aspects of the pregnancy period have described the typical mood swings and shifts of interests of pregnant women. These challenge the traditional teaching procedures. If, for example, expectant mothers are absorbed in themselves during the early months of pregnancy, focusing on their own bodily changes while they are struggling to understand what the coming of the baby really means to them and to their own feelings of adequacy, why should they be expected at that time to discuss the details of the delivery or the care of the newborn? Would it not be better to let such a discussion come at a time when their interest turns naturally to these subjects, as it usually does later in pregnancy?

Such considerations involve the question of the groups' composition. Should each group include only women (and their husbands, if it is a couples' class) who are at approximately the same stage of pregnancy? Our experience has revealed no definite answer to this question. It has shown that groups so formed have both advantages and disadvantages. While the members of such a group could be expected to have more similarity of interests than a less homogeneous group, the latter is apt to have a wider range of ideas and experiences to stimulate the discussion. In any instance, the leader must not only be aware of the predominant interest of the group but also recognize individual differences and at times point them out.

### *The Expression of Feelings*

Another value of group participation lies in the opportunity it provides for the expression of feelings along with the need for facts. Many of these young expectant parents never have the chance to express these feelings. These remain bottled up and may become a core of resentment or irritation which hinders objective thinking.

Take, for example, the subject of nutrition during pregnancy. Our experience has indicated that expectant-parent groups rarely are interested in or feel the need for more information on the "basic seven" food categories. The members get this information from their doctors, from clinic personnel, or from printed material. What many expectant mothers do want from the group, however, is a chance to express their resentment at having to stick to a diet at the very time when they want to eat more and to be indulged and coddled rather than deprived.

After they have voiced their reactions, sympathized with each other, and obtained sympathy from the nurse-leader as to their food difficulties, these young women seem relieved and able to look at the situation more objectively and to see that their own interest as well as the baby's will be furthered if they follow the nutritional suggestions. They become more resourceful about making adequate substitutions for foods they really dislike and accept such ideas readily from one another. Especially important is the achievement some of them make in being able with little or no resentment to serve their husbands foods forbidden to themselves.

It also helps the participants greatly when they express their feelings in the group on many other subjects, when others listen with respect, and when they learn that it is not unusual to have such feelings, both positive and negative. On occasion they even express some of their mixed feelings about the new baby, and learn with surprise and relief that other expectant parents also wonder at times if they really want the baby after all. This may be true even of those who wanted a baby desperately and are in the main deeply gratified and proud that he is "on the way."

Looking at one's own feelings frankly within the safety and protection of the group seems to be the first step in putting them into a proper perspective.

Another point about the value of participation has to do with the interaction between the participants as a result of the group experience. This calls for a look at the way expectant parents make use of the group for their further growth and learning. They gain strength first from the group's support, from learning about others who are "in the same boat," who are thinking and feeling in much the

**A group of parents meeting with a nurse (third from right) in a Child Study Association project to discuss their problems.**

same way about their common experiences. They gain strength too from the interchange with one another. This the nurse-leader can consciously direct toward what for many may be a new kind of understanding—an awareness of differences in ways of reacting toward experience, differences which come from variations in personality, background, and life experiences.

It is these differences, thoughtfully considered in the group discussion, which open the way for different choices of action. Whether parents do or do not choose natural childbirth or rooming-in (where a choice is possible), breast feeding or bottle feeding, whether or not they decide to have their mother or mother-in-law help after they bring the baby home, whatever the area of decision, the important point is that they should have been helped to look at all the issues involved so that their choice is sound for them.

### *Some Other Questions*

We have frequently been asked about the use of demonstrations (the baby bath, formula preparation, and layette) and of visual-aid materials in programs for expectant parents. In our groups we follow no fixed procedure except that of trying to meet the needs of the participants as flexibly as possible. Demonstrations can serve a real purpose in giving expectant parents an idea of something practical they can do, even if they forget completely what they have seen and learn all over again by doing after the baby is born. Such demonstrations can be helpful if they are not offered rigidly as the one way of meeting the situation, but rather are presented creatively, as a springboard for comments and questions from the expectant parents which can be built into the discussion.

Visual materials such as the Birth Atlas can be used flexibly, too, to illustrate points raised in the sessions, without laboring them or following them through to the last detail. Nurses who have watched the reactions of group members to the Atlas' pictures report a wide variation of responses. Some people are fascinated by them, and find them not only helpful but beautiful; others find them too realistic and frightening and look the other way. Almost universally, the nurses in our project found that these materials were more effective if they were used selectively and briefly.

The foregoing is only suggestive of some of the adaptations of teaching methods that can be made in a program based on group participation. Teaching of this kind obviously requires knowledge of both subject matter and the techniques of working with groups. The latter is as yet difficult to acquire as a part of nursing education. Individually many nurses are reaching out in their own communities for help along these lines and are experimenting with new approaches on their own initiative.

Question has been raised as to whether every nurse should be expected to conduct classes of this kind. In our experience, some nurses do not seem suited to this type of work; others develop amazing skill and sensitivity with extra training and with the added help they can be given in practice groups under skilled supervision.

The majority of nurses with whom we have been privileged to work have found this approach stimulating and revealing. Even those who, for various reasons, are not conducting their classes exactly along these lines have said that their experience with group discussion for expectant parents has given them a new knowledge and a greater capacity to listen. They also say they have gained a new awareness of their group members' needs which has permeated all phases of their work with patients.

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[1] Auerbach, Aline B: Public health nursing and parent education: a pilot project of training for parent group leadership. American Journal of Public Health, December 1955. New approaches to work with expectant parent groups: a report on a pilot leadership training program for nurses. American Journal of Public Health, February 1957.

[2] Caplan, Gerald: Psychological aspects of maternity care. American Journal of Public Health, January 1957.

> **A pair of substantial mammary glands has the advantage over the two hemispheres of the most learned Professor's brain, in the art of compounding a nutritious fluid for infants.**
>
> *Oliver Wendell Holmes in* Medical Essays.

*A project report of a study of prosthesis acceptance in . . .*

# PARENTS OF CHILDREN WITH CONGENITAL AMPUTATION

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"IT DOESN'T SEEM to bother Tommy that he was born without a hand. He never mentions it."

As the social worker for the Child Amputee Prosthetics Project at the University of California, Los Angeles, it bothered me when I heard a mother make this statement. Social workers know that a child is concerned about being different from other children even though he may not express his feelings about this. At this project we have learned that the replacement of an arm or hand by a "good functioning" artificial one is not the sole answer to a child's problem and that his ability to use the prosthesis will be largely conditioned by his parents' attitudes.

In 1955 a grant to the university from the Federal Children's Bureau assured the continuance and expansion of an interdisciplinary approach to prosthetics planning with child amputees and their families. Physicians, prosthetists, engineers, occupational and physical therapists, a psychologist, and a social worker came together as a team to learn what constituted a successful prosthetics experience—a well-made artificial limb (in this instance an arm), acceptable and useful to the patient.

The members of the disciplines within the project have sought to obtain information that would: (1) identify the various factors influencing prosthetics planning; (2) indicate methods of overcoming or modifying conditions that interfered with prosthesis acceptance; and (3) suggest the kind of program that could test results and be useful to other organizations working in the same or a similar field. This plan was in keeping with Dr. Bechtol's suggestion that studies should be initiated to learn more about the full import of the loss of a limb to a patient and to his family.[1] Preschool-age children with upper extremity amputations and children with upper extremity malformations were given preference for inclusion in the study because little was known about their problems and the methods of dealing with them. The caseload at present includes approximately 130 children from the State of California.

Established on an outpatient basis, the project requires at least one parent to accompany each child and encourages other family members to participate in all phases of the program. Hospitalization is arranged for a patient when a surgical procedure is necessary. Families who live near the project come from their own homes. Those who live too far away to go and come in a day are housed in a nearby motel, with some of the cost borne by the project if the branch of the State crippled children's service in the family's home community corroborates the need for such assistance.

We have attempted to make the program a family-oriented approach to prosthetics planning, on the theory that the more closely the family unit can be maintained and used as a support for the child the less likely is his difference to dominate his personality and so become detrimental to his development.

Because 80 percent of the children who came to the project had been born with their amputation, we found we were working with parents who questioned their adequacy to produce a complete child, and with children who could not find a satisfactory answer to the question, "What happened?" We suspected that such parents could not accept a substitute mechanical arm for their child if they continued to hope they would wake up from a nightmare to find that he had two perfectly normal hands. Because children tend to adopt the attitudes of their parents we could learn from the parents the child's degree of readiness to accept an artificial arm and be trained in its use.

The project provides time in each case for parent and child orientation and for professional evaluation before a final decision is reached on whether or not to prescribe a prosthesis. Parents and patient are introduced to the project facilities, procedures, and personnel by the administrator. For some parents this is the first time they have seen or even heard about the split-hook type of terminal device. Its appearance offends those who have need for a lifelike hand and sends some of them scurrying for reasons why their child has no need for a prosthesis. Others who may feel the same immediate repugnance to the prosthesis are more realistic about their child's needs.

Following the introduction to the project, the pediatrician examines the patient and obtains the family's medical history. While revealing family history bothers some parents it seems to give most of them a feeling of having something important to contribute to the project as well as to receive from it.

The day after the pediatric examination the social worker interviews the parents and the psychologist tests the child. The occupational therapist also interviews the parents, explaining the nature of the training program at the project and pointing out the importance of follow-up through a therapist in their home community. The parents are told that regular visits to the project will be scheduled 3 or 4 times a year for checking the fit and mechanical operation of the prosthesis and introducing new activities to help the child achieve greater use of the device.

Later, at a staff conference, the question of prescribing a prosthesis is considered in the light of the findings of the team members. Physical therapy or surgical procedures may be recommended prior to prosthetic fitting. The psychosocial factors are considered and therapeutic measures appropriate to the family's needs recommended.

Our experience indicates that readiness for a prosthetics program begins when parents sense they are making a contribution to knowledge through relating family history and participating in social-work and psychological interviews, and when they reveal a capacity to envisage the future through acceptance of responsibility for providing continuity of training.

### *The Social Worker's Role*

Social work in the Child Amputee Project is similar to social work in any medical setting, the casework relationship being the medium for study, diagnosis, and social-work treatment. Through interviews in which facts as well as feelings and attitudes are elicited, the social worker gains understanding of the meaning of illness or disability to the patient and his family and of the patient-family relationships. On the basis of a social diagnosis a plan is made for meeting the social and emotional needs of the patient, his family, and others important to them, in relation to the child's disability, so that the patient might achieve maximum use of the prosthesis prescribed.

Specifically the social worker in the Child Amputee Prosthetics Project:

1. Evaluates the family's readiness to accept the prosthetics program; helps with problems which may interfere with the successful use of a prosthesis; and assists the parents in obtaining help in meeting other needs of the child or of themselves.

2. Functions as a member of the prosthetics team, contributing such information as is appropriate to a better understanding of the patient and his family and helping the family members to understand their relationship to the project and to the various members of the team.

3. Acts on behalf of the family as liaison with other social agencies, public and private, in helping the family gain the greatest benefit from the prosthetics program through the use of other appropriate resources.

The social worker's research goal has been identification of important psychosocial factors indicating a family's readiness for a prosthetics program.

Since social-work literature has little to offer in developing a study of parents of amputees, it was necessary to begin on an exploratory basis. Before setting up a specific research project, recordings of social-work interviews with a selected number of parents of 20 child amputees were reviewed. These interviews had been carried on in an unstructured manner to allow parents to express concerns about themselves, the project, the child, and the prosthetics device. On the basis of the findings of this review a pilot study was developed. This was limited to new requests for admission to the hospital and involved the parents of 25 congenital amputees.

It was our impression that a family's general life pattern, experiences at the time of the birth of the patient, quality of relationships both in and outside the family group, the nature of communication among the family members, and the parents' capacity to involve themselves in a social-work interview had a direct bearing on the patient's readiness to proceed with a treatment program. In order to test this hypothesis we sought to identify in our analysis the parents' attitudes toward their child and his amputation, their reasons for coming for treatment, and their ability to accept help for the child and themselves.

### *Study Results*

Following are some of the preliminary findings based on interviews with the parents of the 25 children with congenital amputation.

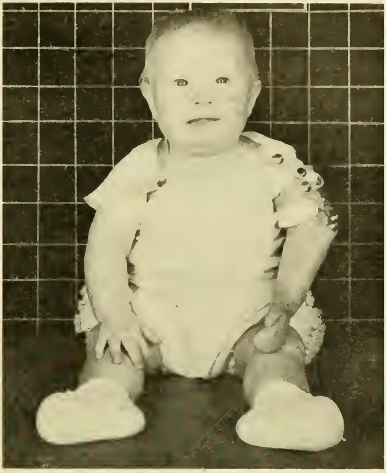
Parents apply to the prosthetics project for a variety of reasons and with varying degrees of understanding of prosthetics and of themselves. They can be classified into three groups:

**1.** Parents who have sufficiently coped with the traumatic experience of having given birth to a child with an anomaly to be able to discuss the disability realistically; who realize and accept the child's need for both independence and dependence; and who have so freed themselves from self-blame that they can communicate understanding to the child and be helpful to him with his own problems of being different from other children.

**2.** Parents who are bewildered by the problems that are created by a child who is different; who continue to be troubled by a feeling of having caused the anomaly; who express concern about the reactions of strangers, friends, and relatives to the amputation and to a prosthesis; but who have the strength to look at their reactions and concerns and to make use of help.

**3.** Parents who have attempted to absorb the child in their own needs and conflicts; or who have isolated the child through avoidance of communication or insistence upon complete self-sufficiency; or who have withdrawn from close association with the family by illnesses or flights into activity; and who in defense deny the need for help.

The birth of a child with a congenital amputation does not necessarily cause the family to adopt a new pattern of behavior, but more often provides the critical incident that reveals the ways the members of the family handle stress individually and as a group. The stress is sudden and brought about by an event which is irrevocable and loaded with notions of misdeeds and punishment. "What did I do wrong?" is an almost universal question of mothers of congenitally deformed children.



**At 7 months of age this little girl wears a simple prosthesis which is used for two-handed holding and pushing.**

Sound planning for a prosthesis must include recognition of the responses of the child's parents to his amputation for they tend to repeat similar responses in varying degrees when they see their child wearing a prosthesis.

The children of the parents described in the following three groups all have a short below-elbow type of amputation.

### *Parents in Group 1*

Parents in this group have been able to handle their feelings and are not inclined to dwell in their discussion on their possible responsibility for the malformation, on possible concealment of the amputated side, or on a resolve to act differently toward this child because they "did not give him a hand." These parents ask for help with specific problems they recognize in the child and in themselves. They may, for instance, express worry about the effects on the patient's brother or sister of focusing so much attention on the patient. They are not so absorbed in their own needs that they cannot see the needs of others.

A mother in this group spoke of her immediate feeling of self-pity after her child Ricky was born. As she lay in her bed in the maternity ward she observed patients and visitors looking in at her as they passed down the corridor and was certain they were saying, "That is the mother of the baby without a hand." Later when she was permitted to walk around she discovered she was looking into each room as she went by. She thereupon realized what harm she could do to herself and her family by expecting people to point fingers at her. She spoke of the closeness she felt toward her husband before Ricky's birth, but added that from the moment he told her about the absence of a hand in the child their shared sorrow brought them still closer together and became a source of strength.

Ricky is not a compliant child, but a boy with energy and curiosity. His mother has learned when and how to loosen or tighten the reins and to distinguish those of his troubles which arise from being different and those which are typical of any little boy of 4. She told the social worker about incidents that had happened and how they were met. She also discussed the problems that Ricky might meet as his world expands. She knows her child is different because he has only one hand, but she has learned there are ways of keeping him from being overwhelmed by this difference.

### *Parents in Group 2*

A majority of parents in the study were classified in the second group. These parents most often talked about problems which revealed inability to be consistent in discipline, overconcern about appearance, discomfort with the curiosity of outsiders, and difficulty in understanding their own feelings. Fitting and training were delayed for the children of some of these parents until the parents received help with their feelings and attitudes, so that they in turn could be more helpful to their children. So it was with Tommy, mentioned in the beginning of this article.

As Tommy's mother expanded on why she believed his lack of a hand did not seem to bother him, it became apparent that he was not the only uncommunicative member of the family. His mother and father had talked very little with each other about their feelings of being parents of a child born with an amputation. The mother expressed concern about the father, sensing his distress about Tommy's anomaly, but had not talked to him about it. On two occasions when she had seen Tommy crying after people had made remarks about his stump, she did not speak to him about these incidents and he never mentioned them to her.

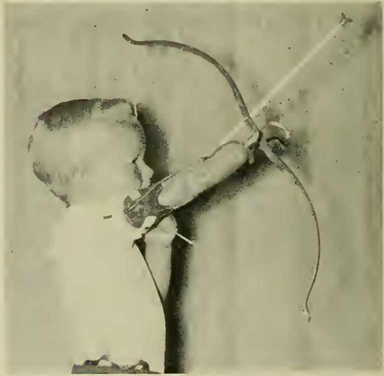
The mother brought Tommy to the project when he was 10 because she thought he should learn to use a prosthesis at this age in preparation for the day when he would need to be employed. Tommy would not talk about his amputation or the need for a prosthesis.

Following a recommendation that prescription for a prosthesis be delayed, casework with the mother was instituted. The focus was on helping her to communicate feelings to the social worker and to find ways of establishing communication with her son. At the same time Tommy had an opportunity to observe other patients being trained in the use of a prosthesis. After a few months Tommy requested an artifical arm and talked with his mother about some of the reasons for his desire. During the period when he was being trained in the use of his prosthesis, his mother and the social worker discussed ways of preparing his school for his appearance with it. Through this experience the mother found additional ways of communicating to her son her understanding of some of his difficulties.

Prostheses were recommended for the children of some parents in Group 2 with the understanding that the parents would receive casework help while their child received training. This was true of 4-year-old Sally.

Interviews prior to prescription with each of Sally's parents had revealed they had difficulty in setting limits for her and were preoccupied with her appearance. Although the mother could not talk about the child's birth, the father had graphically described his reactions: "I had to keep telling myself, 'she is my child and I have to make it somehow or another'." He also described how the mother cried when she came home with the baby and had looked in a closet at the dresses of Sally's older sister, remarking that Sally could never wear puffed sleeves, because everyone would see she had no hand.

The split-hook type of prosthesis, as worn by this 3-year-old archer, enables the child to hold and to manipulate.



During the training period, interviews with the father and mother revealed that their reactions to the prosthesis presented difficulties not too different from those experienced with the amputation itself. Frequently the mother asked if Sally should wear her prosthesis to this or that place, reflecting her concern about appearance. Although the parents said that their two daughters were handled in similar ways, they indicated that they felt guilty when Sally had to be punished, a fact which the child exploited.

The occupational therapist and social worker worked out a plan together to allow the mother to be present during the latter part of each training period only. The therapist was firm in her training approach with Sally. This plan worked effectively with Sally and although exclusion from the training room aroused the mother's anxiety, it helped her focus more quickly on her problem.

The mother continues to be concerned about appearance but has become less anxious about permitting Sally to make good use of the training program and about disciplining her. This latter gain has also helped the older sister's behavior.

The parents in the second group seem to believe they should not give vent to their feelings because they have been told so many times they should be grateful that the disability is no greater than it is. A mother of a 15-year-old boy expressed her reaction to the social worker. "For the first time since he was born, I feel I can let go and talk about me."

The families in this group have one important characteristic—at least one parent has the capacity to look at his reactions and make use of help.

### *Parents in Group 3*

The parents of the third group pose problems in relation to themselves, the patient, and the project. Most of them have come to the project because they had been told they should do this to benefit their child. The need to assuage their guilt is so great they accept the referral.

The personality difficulties of many of these parents are so deep seated as to interfere with the effectiveness of working with the child. Some have so absorbed the child he cannot function independently of the parent. Some ward off professional help through a consistent depreciation of the services. Some interrupt or completely cancel their association with the project on the basis of their own ill health or other excuses.

These parents have so internalized their problem they cannot tolerate a program that is designed to deal realistically with the amputation. Those who have remained in the project have taxed the energies and skills of all the personnel.

Danny's mother explained in the initial review with the social worker that she experienced no shock when the doctor told her Danny had no hand. She told of seeing this condition in a vision before he was born and said that she knew then that she would "be his other arm." She carried out her resolve to such an extent that at the age of 7 Danny did not share in any of the household tasks expected of his four older brothers and sisters and had been allowed to sleep with her almost every night since infancy. She described her anger when anyone brought up the subject of Danny's arm.

At 7 Danny acted like a 3-year-old. Psychological testing revealed that he was emotionally but not mentally retarded.

The team's decision to prescribe a prosthesis for Danny was made with full knowledge that its proper use might be impeded by the severe emotional problems in parents and child, and that these would have to be analyzed in an effort to find ways of dealing with them.

Attempts to involve the mother in casework interviews each time Danny came to the project for training bore little fruit until she expressed some concern about her son's continued desire to sleep with her. The social worker used this bit of anxiety to stimulate in her a desire to understand more about her child. When Danny showed signs of failing in school, the mother's anxieties became so acute that she was willing to accept a psychiatric referral. This was a full year after the prescription of the prosthesis. Until then Danny had made little use of the prosthesis although he and his mother had kept all their appointments at the project. Some progress is now evident, but the problem within the mother is of such long duration and Danny's emotional development so retarded that good prosthetic use cannot be achieved until the emotional disturbances have been ameliorated.

In dealing with parents in Group 3, the prosthetics project is faced with a major therapeutic problem. Recognition by a professional person that a patient needs psychiatric care does not mean the patient can accept this. Thus a few parents have refused to continue with the program and have terminated their contact during the orientation-evaluation period.

When this happens the project explains the fact to the State crippled children's service worker in the family's home community who may initiate there whatever services may be available, and whatever devices may be possible in helping the family move toward an acceptance of professional help. Our project is too new for us to be able to tell how many and how soon such parents may return to us for help. Some may reject any further contact with the agency that referred them to such a disturbing experience.

The children of some of these parents have had other physical conditions requiring treatment. One parent is receiving casework services in a cleft-palate program. In some cases the child's behavior at school has prompted the school to initiate help.

### *Discussion*

Conceivably the parents in Group 2 would become more like those in Group 1 after, or if, they have been able to achieve greater understanding of the cause of their reactions to their child's anomaly. Some parents of Group 3 may be able to effect some change within themselves, but the process of doing this will undoubtedly require a long time and in most cases the changes will be small.

The social worker's determination of the families' readiness to enter the prosthetics project helps the occupational therapist to plan programs differentially to meet the needs of individual children. Parents who have been freed from involvement with their own problems can be expected to grasp the intent of a training program and follow through with it at home. Parents who are still struggling with the question of whether the child should wear the prosthesis outside the home or at all are not able to turn their attention to the function of a prosthesis.

Evaluation of the potential of the patient and parents for prosthesis acceptance becomes critical when viewed in the light of the limited community resources for this type of care and the costs of such care. It is unwise to expend $200 to $500 for a prosthesis when the family is not ready to accept the need for it. An initial failure with a prosthesis may make it even more difficult, if not impossible, for parents and child to achieve motivation toward prosthesis acceptance at a later date.

The Child Amputee Prosthetics Project is evaluating the methods that determine readiness and the factors within the patient and family that may contraindicate an immediate prosthetics program for the patient. This is but one of the many facets of the program and of the social worker's part in it. Few projects as extensive and intensive as this one are available throughout the country. However, if our findings on readiness are valid, projects of a more limited nature, supplemented by existing services within communities, may be able to use them in providing sound prosthetics programs.

Further research is necessary to find ways of helping many child amputees and their parents to a successful acceptance of prosthesis.

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[1] Bechtol, Charles O.: Artificial limbs for child amputees. Children, May–June 1954.

We must encourage new explorations and not choke off speculations, guesses and hunches. It is out of such approaches that science grows. At the same time we should cultivate our observational abilities to evaluate new directions pointed out to us and be flexible enough to test them adequately. As Schilder said "If an idea sounds good it has a good chance of being right."

However, this does not mean that we should go off on tangents or be lured by wonderful sounding but unproved premises that can so easily become fashionable just because they are repeated in accordance with the white queen's statement to Alice—"If you say a thing three times then it becomes true." The exploration of new hypotheses may open many otherwise closed doors but we must recognize that most of them will have to be closed again.

*Reginald S. Lourie, M. D., to the 1958 annual meeting of the American Orthopsychiatric Association.*

# EUROPEAN RESEARCH IN CHILD PSYCHOLOGY

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THIS REVIEW of current European research in child psychology is necessarily partial. It cannot pretend to approach a full description of the work going on in the 18 major countries of Western Europe and in those of Eastern Europe from which information can be obtained. It must of necessity dwell upon those centers of research which are of principal interest to the reviewer and to those who have counseled him.

## *European Trends*

There is considerably more activity in Europe than there is in the United States in research on language development in children and in the mechanism of memory. The most productive recent research in problem solving and formation of concepts by children has come from Europe, especially from Geneva through the works of Jean Piaget and Barbel Inhelder. There is also a good deal of interest among European research workers in the interpretation of children's drawings.

On both sides of the Atlantic interest in the adaptation of the child to society is steadily growing. While the adjustment of the child to the accepted characteristics of the community in which he lives continues to receive attention, at the same time increasing effort is focused on finding ways of building healthy, independent individuals capable of creating the society of the future. The capacity of children to adapt to various cultural patterns seems to have been clearly demonstrated by several careful works in cultural anthropology, some of which have indicated that the children best adjusted socially were also the most intelligent and came from stable homes. While these demonstrations are largely of American origin, the works of E. Boesch in Switzerland and of H. T. Himmelweit in England, among others, have also made significant contributions.

Considerable attention has been paid in Europe, as well as in the United States, to the function of independence. The results of experiments in the United States, France, and the Soviet Union appear to agree on the difficulties presented for the development of independence in some children by entrance into nursery school. Major work on the emotive problems of adolescence corresponding to puberal change is largely American, but Swiss and Russian workers, especially M. Debesse, G. Sobieva, and T. V. Dragounova, have also considered these problems as related to identification with others.

## *Mental Growth*

A number of European studies of mental growth are currently under way. The Institute of Education of the University of Geneva has planned a longitudinal growth study to cover 3 years in the lives of 4 groups of children of overlapping ages, ranging between 5 and 14. A small number of children—20 in all, 5 in each age group—are being examined in regard to cognition, perception, and social interaction. This includes a number of possible tests for cognition, some tests for perception, and one or two for social interaction. Altogether about 40 tests are given to the children, about 20 for each age group, with some overlapping. Some tests are standardized but others are in an experimental phase.

This work at Geneva is important not only for the information which it will provide but also for the imaginative new procedures which are being developed. As yet there is no correlation with physical development, but information on the children's socioeconomic backgrounds is available. The work is being done by Barbel Inhelder and Gerald Noelting. The children are always seen by the same two observers.

Inhelder is conducting a further study of the growth of children in families where relatively frequent changes of principal figures take place, as in homes with nursemaids who change every year or so. The results will be interesting to compare with Bowlby's well-known description of the damaging effect of maternal deprivation on young children. The effects of maternal deprivation are currently being studied in Zurich at the Childrens Hospital, which is also carrying on some longitudinal studies using the Brunet-Lezine tests on infants. At the University of Genoa a group headed by Amedeo Della Volta is focusing on the psychomotor development of infants and young children. The group has considerable experience in Rorschach testing through the various phases of childhood. Genoa is the only university in Italy with an institute devoted entirely to child psychology.

A Norwegian group in Oslo headed by Gruda Skard has been carrying on a program since 1951 studying child development and parents' attitudes. Twenty-one families have been under study with the object of comparing the development of Norwegian children with that described in other countries, and to examine whether supposedly important factors causing difficulties in problem children have not also been present in the lives of supposedly normal children. After five years 18 families remain under observation. Results are not yet available.

In Paris, Irène Lezine is observing relationships between postmaturity and prematurity and mental development, and Odette Brunet is pursuing her longitudinal studies of the development of infants from birth onward.

### *Perception and Intelligence*

In Geneva Jean Piaget is experimenting further with the evolution of perception, especially in respect to distance and speed. He is comparing the perception of children of different ages with that of adults, focusing principally on the relationship between perception and the formation and development of concepts and on the interaction between the two.

The doctor and boy he examines are participating in the Harvard-Florence research project in Italy. Selected boys in two schools are examined annually to assure continued likeness of pairs being compared for achievement.

Piaget, Inhelder, and colleagues have for a number of years also been studying the perception and classification of objects and pictures in children from 3 to 8 years of age. Having examined the merits of various hypotheses regarding the development of intelligence, they decided the matter was so complex that investigators must limit their field of study in order to obtain results. Thus they chose the field of object classification and are studying perception and its subsequent application when the child solves everyday problems. A book describing this work is in course of preparation.

In Eastern Germany K. Gottschaldt has investigated further the perception of numbers. With the child in a playpen he observed performance and behavior as the situation became more and more difficult.

The Tavistock Clinic group in London, with which John Bowlby is associated, has been studying, among other phenomena, the function of understanding in small children in the presence and absence of the mother.

Some of the studies of children's perception of art, especially those by J. Subes in France, indicate that in judging paintings of different styles children 5 to 7 years of age prefer abstract art, but when they become older they prefer realism. In the Soviet

Union the drawings of children are interpreted as an attempt to see reality and to present it clearly for others.

The Russians are also studying language development, and their results seem to identify language as an important factor in the function of concepts. In Moscow, A. R. Luria is interested in language as a social function and has been investigating the influence of language ability upon thought processes.

In Paris Odette Brunet and Rene Zazzo have examined language function in three groups of small children: (1) children from professional classes; (2) workmen's children raised by the mother; (3) workmen's children raised by a person other than the mother. These studies seem to demonstrate that acquisition of language skills decreases progressively in the 3 groups. That Zazzo is preoccupied by method is at once apparent to any reader of his critical paper on the use of twins for experimental work.[1]

Jean Piaget has also conducted language studies and has come to the conclusion that in the child language follows thought but stimulates further elaboration of thought processes.

Bowlby is also interested in the development of language ability.

### *Personality Development*

In Switzerland at the University of Berne, R. Meili is studying the personality development of 26 normal children from birth onward. This longitudinal study has now arrived at the 6-year point. Besides observing early individual differences Meili is giving special attention to the development of emotional behavior, with emphasis upon anxiety and frustration.

In Western Germany Hans Thomae at Erlangen University is continuing longitudinal studies on constitutional types. His particular interest is the possible relationships of acceleration and retardation in physical growth with the development of intelligence and personality. He has observed a general tendency toward higher intelligence and more mature personality in physically accelerated children and has identified varying maturation speeds in the factors which go into general development.

R. W. Parnell and colleagues at Oxford have been studying a number of chidren classified at the age of 7 according to physical type, and have observed a greater incidence of signs of emotional unrest in the ectomorphic (lean and fragile) type. The investigators emphasize, however, that although the tendency toward unrest apparently continues in this group throughout childhood and the college years, a number of the most brilliant students come from this group.

In France, Zazzo, the originator of "Le Bestiaire" a test in which the child is asked to name, among other things, which animal he would like to be and which he would not like to be, is now emphasizing the importance of also asking the child what animals he likes and does not like. Confusion between the two ideas of what the child likes and what he would like to be must be avoided, he points out, to avoid difficulties in analysis.

### *School-Age Children*

In Florence, the Harvard-Florence Research Project, in collaboration with the pediatric clinic and with the University Institute of Psychology directed by Alberto Marzi, has been studying the effects of progressive education upon personality development in elementary-school children. Paired children have been studied for periods up to 4 years, one of each pair being in the experimental group and the other in the control group. Physical condition, socio-economic status, age, educational level, and intelligence were used for pairing, the factors being controlled for constancy during the period. A number of projective and semiprojective tests were applied during the course of the research.

The paired children are students in two elementary schools—one run along "progressive" lines, where a certain amount of freedom in expression, behavior, and selection of activities is allowed, and the other run along traditional, didactive lines. The children in the experimental group attend the progressive school and the children in the control group, the traditional school.

While the results of this experiment have not yet been published, a preliminary analysis indicates that the progressive method of education has no marked influence upon development during an initial period which may extend up to 2 years. Thereafter, however, progressive education seems to stimulate increasingly the growth of certain features of the personality which many persons feel to be important for the development of social maturity. It does not seem to bring any advantages in respect to purely scholastic achievement.

Other activities of the Florence group include a fresh approach to school health. An experimental service has been set up to obtain a broad view of each student, including such factors as intelligence, social maturity, socio-economic status, so that those not fulfilling reasonable expectations may be readily identified.

In London the National Foundation for Educational Research is proceeding with experiments[2] designed to examine critically Great Britain's present procedures for selecting children at the age of 11 for certain types of advanced education. This work originated in a suspicion that the potential of many children is being overlooked and that some are being selected who will turn out to be an unwise investment. The object is to help persons achieve their most appropriate place in a changing society in the kindliest manner possible.

In Poland Alina Szeminska, who for some time has been investigating methods of selection for adoption and the placing of motherless children, is now studying a number of the problems presented by school children.

### *Behavior and Psychosis*

Della Volta in Genoa is using a multidiscipline approach, including electroencephalographic examination, in following children with behavior difficulties. He has also studied alcoholism in children and its relationship with the same phenomenon in the adult.

James Anthony at the Maudsley Hospital in London has been studying object formation in psychotic children. While his work depends to some extent upon some ideas of Piaget, he has introduced some new and critical avenues of approach. He has observed that when, as occasionally happens, such children regress to the point where they are no longer capable of retaining the concept of object as something relatively unchangeable, they no longer suffer anxieties such as those usually caused by separation from parents.

In Moscow, B. M. Teplov has been observing mentally defective children, focusing on their motor and cognitive development.

### *Liaison Needed*

In the *Annual Review of Psychology* (1957),[3] Inhelder has referred to the observation of Wayne Dennis of New York that while widespread concern with problems of education, personality development, and child rearing exists in most countries genuine experimental attacks upon these and related problems are extremely few. Dr. Inhelder suggests that liaison between child-study centers and psychology laboratories might be improved.

Such liaison might be developed not only within separate countries, but also on an international basis. There is no reason why the Atlantic Ocean should act as a barrier to such activities.

The author is indebted to Professor Inhelder for the quantity of valuable information she has made available during the writing of this article, and to Dr. James L. Whittenberger of the Harvard School of Public Health for his helpful suggestions. We hope this brief glimpse of what in reality covers a much wider and varied range of activities than can be described here will at least give some idea of the vitality and broad interests in experimental child psychology in Europe.

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[1] Zazzo, R.: Sur le postulat de la comparabilite dans la methode des jumeaux. ACTA Geneticae Medicae et Gemellologiae, vol. IV, 1955 (p. 180).

[2] Yates, A.; Pidgeon, D. A.: Admission to grammar schools. National Foundation for Educational Research in England and Wales, publication no. 10. London: Newnes, 1957.

[3] Inhelder, Barbel: Developmental psychology. Annual Review of Psychology, Volume 8, 1957.

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**"Wherever home is spelled with a capital 'H,' there will be the look in the eyes of the child. It is infinite longing and loneliness at first. A few years later, when disuse has atrophied even his capacity for affection, it is dull, stoical indifference . . . And it is this dull, stoical indifference that slumbers like dangerous dynamite within the institutional child. At first, when nobody cares for him, he is only sad. Later, when he cares for nobody, he is unsafe."**

*Mabel Potter Daggett, in* **The Delineator,** *November 1908*

*Some functions in an over-all community program of . . .*

# CHILD-WELFARE SERVICE FOR THE MENTALLY RETARDED

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SOCIAL WORKERS have long recognized that social phenomena are vital factors in child development and that a child's problems and needs must be considered in relation to his environment—his family, his culture, and his community. Of these interacting forces, the child's relationship with his family has the greatest significance, for in the family his basic needs for love, security, and physical comfort must be fulfilled. While other social institutions such as churches and schools may contribute much toward the child's adjustability, their effectiveness depends largely on the extent to which their teachings are reenforced by the family. Since not all families discharge their responsibilities adequately, society has developed child-welfare services as one means of helping parents to provide their children with an opportunity for a satisfactory living experience.

In fulfilling these functions, public and voluntary welfare agencies have thus far largely neglected children handicapped by mental retardation. The needs of these children for diagnostic services, including pediatric, psychiatric, psychological and social services, special education, and training, comprise a major problem. This article will suggest some of the ways in which child-welfare services as part of a total community program can more adequately help mentally retarded children and their families. Many of the considerations to follow are also applicable to other social workers.

### *Who Are the Mentally Retarded?*

The American Association on Mental Deficiency defines mental retardation as "that group of conditions which is characterized by: (1) inadequate social adjustment; (2) reduced learning capacity; (3) slow rate of maturation."[1] These conditions may be present singly or in combination. They result from subaverage intellectual functioning which is usually present from birth or an early age. The association further defines mental retardation as "basically a symptom complex resulting from a wide variety of conditions including not only defects of the central nervous system but also those in the psychological and sociological spheres." It also points out that the psychological and social factors not only operate as causative mechanisms but may also play significant roles in influencing the degree and nature of mental retardation based on organic defect. This concept, in stressing the dynamic as opposed to the static elements in the condition, suggests that many mentally retarded children can be helped through treatment, education, or other thera-

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Based on a paper presented at the 1957 Biennial Round Table Conference of the American Public Welfare Association.

peutic procedures even though the basic cerebral defect may not respond to remedial measures.

Because of the varying definitions used and the difficulty in applying the concept of social inadequacy, no accurate figures exist regarding the number of children or adults who may be classified as mentally retarded. It is safe to say, however, that those who fall into the lowest intelligence classification (persons incapable of achieving any degree of self-care) are a small minority of the total group. Comprising about 3 percent of all mentally retarded persons, many of them are physically as well as mentally handicapped. About 13 percent of all the mentally retarded are moderately retarded, semidependent, capable of self-care and the acquisition of simple work skills under sheltered conditions.

The remainder, or 84 percent of the retarded group, consists of persons who fall into the very broad and complex category of mild or borderline deficiency.[2] Many of these children have no demonstrable defect of the central nervous system. In some of these children poor intellectual functioning is due to social and cultural deprivation, superimposed upon a subnormal intellectual endowment. Their failure to adjust socially results partially (perhaps even primarily) from personality and behavior disorders resulting from environmental inadequacy, insufficient guidance and the negative effects of undesirable association.

Mentally retarded children with cerebral defect are born to families from every socio-economic class in society. On the other hand, children whose deficient functioning comes from a combination of sociological causes and poor endowment generally come from culturally and economically deprived families. In many of these families the child's retardation may be but one of a host of problems.

The tremendous variation in conditions of mentally retarded children is illustrated in the following cases:

Randy, a severely handicapped 5-year-old, has never been able to sit unsupported, cannot feed himself, is completely unresponsive, and is unable to communicate in regard to his most basic needs. The extent of Randy's handicap, the result of a birth injury, has been known to his parents since his early infancy. They were told at that time that the child would not live beyond 2 years of age and were advised to seek institutional care. State care, however, was not available for so young a child, and the family's moderate income was not adequate to afford private residential care.

The parents are intelligent people from an average socioeconomic background. The mother has a deep emotional investment in Randy despite his unresponsiveness. The burden of his care is a serious drain on her energies and she is unable to devote sufficient time to the needs of her other child. Her chronic fatigue and nervous tension is a serious threat to the stability of the home.

* * *

Freddy, a 10-year-old Mongoloid child, is the youngest of 4 children. Psychological tests indicate that he functions at a 4-year, 3-month mental age level, can benefit from social habit training, and can learn simple tasks. The rural community in which he lives does not provide facilities of an educational or recreational nature for children with this degree of mental limitation.

Freddy is in good health, is not a behavior problem in the home, and is well accepted by his brothers and sisters. He has few opportunities for social relationships with children of his own age and occupies himself with simple household chores.

Freddy's father is a skilled laborer and earns an income adequate for the needs of his family. Although Freddy has not presented any unusual problems of care to this time, the parents are concerned about his approaching adolescence. They wonder, too, who will look after him in the event of their death.

* * *

Joan is an attractive, physically mature, 16-year-old girl, born out of wedlock. She has a history of petty theft and has occasionally demonstrated aggressive, hostile, and anti-social behavior. She lives in a deprived neighborhood with a high incidence of delinquency and associates with adolescents whose behavior is characterized by keeping late hours, drinking, and sexual promiscuity.

Joan's mother, who is of borderline intelligence, also has exhibited a degree of social inadequacy. She has entered into common-law relationships with several different men. Her work history is unstable so that she has had to receive public-assistance funds for a number of years. She has close emotional ries and genuine affection for her daughter. Her awareness of Joan's limitations and need for supervision is, however, dim.

Joan attended special classes in the public school system from the age of 8 until her exclusion at age 16, on the basis of having achieved her maximum education potential. She is able to read and write satisfactorily on the 6th-grade level, but has not yet developed any work skills.

## *Social Diagnosis*

An integral part of the casework function in child-welfare service is a skilled appraisal of the capacities, limitations, and resources of a child and his family. In instances of mental retardation, when psychological and social factors may further limit inadequacies due to cerebral defects or other causes, a careful social diagnosis is of paramount importance. Limited intellect is but one of many factors which cause social insufficiency. Many persons of subaverage intelligence are socially adequate, whereas others of good intellect but suffering from neurotic disorders, psychosis, or personality defects, are not. It is not uncommon for children with mild retardation to develop some form of emotional disturbance which further depresses their level of functioning. Equating mental subnormality with social incompetency ignores the importance of other factors and is not in accord with current knowledge on the psychodynamic aspects of human behavior.

Clinical experience suggests that some children regarded as mentally deficient are more emotionally disturbed than mentally impaired. Thus, early identification and diagnosis of children not functioning well are essential from a standpoint of prevention of retardation as well as of treatment. The child who is slow to respond to parental demands, retarded in his physical development, and unable to compete successfully with children his own age is particularly apt to provoke feelings of anxiety and frustration. Parents of such a child are likely to have feelings of guilt and self-doubt. The resultant intrafamilial tensions present an unfavorable milieu for the child's healthy personality growth.

Helping such parents to recognize and accept the fact that their child is retarded does more than alert the family to the child's special needs in home training and management or for a nursery school experience. It gives the parents an opportunity to adjust their goals for the child in accordance with his actual potentials, relieves them of frustration based upon unrealistic aspirations, and facilitates the development of positive relationships between the child and his parents as well as between the child and other members of the family. In this manner, the child's incapacity for social living may be limited only by his degree of intellectual retardation rather than also by a complexity of social and emotional disturbances.

Child-welfare workers are frequently in a position to help in this identification and diagnostic process. They know of such children in the caseloads of public welfare agencies on the basis of problems not directly related to the child's deficiency. Some of them are referred to them by the school, the juvenile-court judge, other social agencies, a neighbor, or a parent because of behavior problems or apparent neglect or abuse. Social workers need training in recognizing deviations from normal growth and development and in identifying the many factors which may cause a child to function at a subnormal level.

Diagnosis in a clinical or social sense involves in most cases the combined efforts of several professional disciplines, working as a team. The physician must determine the child's physical limitations, the etiology of the disability, and the nature and degree of organic impairment; the psychologist must determine the child's capacity for learning, his special abilities or disabilities, the total personality configuration, and its implications for successful social adjustment: the social worker must determine, on the basis of the dynamics within the family, the extent to which family experiences have impeded or expedited social growth and the emotional and material resources of the family to meet the child's special needs. None of these factors can be readily determined on the basis of a single interview or examination. They emerge clearly only in a continuous form of evaluation.

So many factors may affect a child's rate of learning, maturation, or social competency that prognostic predictions, particularly during early childhood, are extremely hazardous. Many children identified as mentally retarded during their school years and thought to have limited potentials for economic productivity develop into stable and self-supporting members of the community. The child-welfare worker must maintain continuous contact with the family and keep abreast of its changing needs.

Problems of social and emotional adjustment may occur at every age and at every stage of development. Though other needs such as maternal and child-health services, special education, or vocational rehabilitation may assume primary importance for children in specific age groups or with certain handicaps, the family's need for help in providing the child with a successful social living experience arises in all groups and may play an important part in determining whether the primary service provided is effective.

### *Social Treatment*

The major purpose of diagnosis is, of course, to offer a basis for the formulation of a sound treatment plan. What can the child-welfare worker contribute in a total service program?

The birth of a defective child is an extremely traumatic experience for every normal parent. In a child-centered culture such as ours the meaning of parenthood has deep ego significance. Parents are prone to make strong emotional investments in their child even before it is born. It is extremely difficult for them to give up the emotional gratifications anticipated from the social and educational achievements of a normal child and to avoid the feelings of guilt and shame that are apt to arise when the child is retarded. Such feelings are natural reactions to intense ego frustrations, but the frequent tendency to explain parental behavior on the basis of these emotions alone is an oversimplification. Because all parents react differently to their children no matter what specific abilities or disabilities the children may have it is important to understand the parents' life experiences as children, adults, and parents, for these determine their reactions to their children, whether normal or retarded.

Parents are often susceptible to well-meant, but ill-founded, advice because of their own ungrounded fears and misconceptions regarding mental deficiency. They are frequently advised that other children in the home will be adversely affected by the presence of the retarded child. They may be told further that as the child matures into adolescence and adulthood, his child's mind will be unable to control the urges of sexual drives. Undoubtedly, many cases can be cited to support such contentions, but any approach to the mentally retarded as products of a single mold has little validity. The child's social competency depends a great deal upon the social demands made on him by his family and the community. Research regarding the social nature of mental deficiency indicates that in underdeveloped countries the mildly retarded are able to adapt to the social and cultural value system of their society, which is less demanding than ours.[3]

### *Adapting the Environment*

One of the responsibilities of the child-welfare worker is to help create for the child as far as possible an environment in which the social demands made upon him are within the realm of accomplishment; where he is protected from situations dangerous to his welfare, yet not overprotected to the point where dependency is unnecessarily prolonged; where the attitudes of his parents and his brothers and sisters are accepting and understanding yet not overly sacrificing.

The child-welfare worker can help to create this therapeutic environment in the following ways:

1. ***Casework interviews with parents.*** These may be directed toward (*a*) interpreting the child's abilities as well as his limitations; (*b*) relieving parents of the anxieties, conflicts, tensions, and frustrations the child's condition arouses; (*c*) helping parents to solve marital or family problems that might be distinct from the child's handicap but which may impede emotional development.

2. ***Concrete assistance when needed.*** This may include making arrangements for financial aid to the family or medical or nursing care. Some retarded children, because of extensive medical needs or their prolonged dependency, are an extreme financial burden to their families, but no child should be separated from his family on the basis of financial need alone. The emotional needs of retarded children are the same as those of other children. Moreover, institutional care may in the final analysis be more expensive to the community than direct assistance payments.

3. ***Arrangements for homemaker services.*** This is another resource the worker can call upon to preserve family strengths and unity. In many instances, freeing the mother from the burden of constant care and supervision of her retarded child, thus enabling her to meet the needs of other family members, may prevent family disorganization. In some families with retarded children homemakers may also be used effectively in a teaching capacity—demonstrating better methods of home management and child care to immature, inadequate, or retarded mothers who without such guidance may be unable to function satisfactorily as parents.

4. ***Arrangements for day care.*** Placement of the child in a day-care center, a family day-care home, or a nursery school appropriate to his needs often relieves pressures in the home. The mother may need help from the child-welfare worker in accepting such an arrangement as providing opportunities for growth for the child as well as relieving her. Frequently the child with mild retardation can be included in a group of normal preschool children.

5. ***Foster-family placement.*** This may have to be considered for some children whose parents, for varying reasons, cannot adequately fulfill their parental functions and responsibilities. While a child's sense of security is more likely to be maintained in his own family, in some circumstances removing the child from home is undoubtedly the wisest course. Where this means must be resorted to, the child is more apt to find emotional security in an intimate relationship with substitute parents than in the comparatively impersonal atmosphere of an institution. In addition to providing obvious advantages over institutions for social and emotional growth a good family atmosphere may stimulate the rate of learning in some retarded children.

Many retarded children have been placed in foster families by child-care agencies, but frequently the agencies regard such placements as stopgaps pending institutionalization.

As we learn more about the meaning of separation to the child and his parents, the need to strengthen and preserve the family despite certain lacks in the home warrants greater emphasis.

**6. *Referral to group-recreation facilities.*** Such resources provide further means by which the environment can be better adapted to the needs of the retarded child and his family. Retarded children often lack the opportunity for normal social companionship. Having little status with their peers some of them seek recognition through antisocial or delinquent forms of behavior. Supervision of group activities by a skilled groupworker can frequently channelize otherwise destructive energies into constructive avenues of behavior, thereby increasing the child's happiness and sense of worth.

**7. *Arrangements for institutional care.*** For certain children this may be the most appropriate resource. The child-welfare worker can provide for continuity of service by participating in precommitment and postdischarge planning and followup services to children returned to their own or foster homes. Even where continuous custodial care is required, the family may continue to need help in adjusting to placement. Institutions should be considered as part of rather than separate from community resources.

## *Developing Social Competency*

Along with the responsibility for adapting the environment, as much as feasible, to the needs of the retarded child the child-welfare worker has responsibility for seeing that the child receives help in developing greater social competency. The first step in this direction for the preschool-age child is through the development of motor skills, coordination, and other abilities that may eventually permit a reasonable degree of self-care. Helping the mother to further such developments is the function of a public-health nurse, occupational therapist, physical therapist, or child-development specialist. However, the effect of parent-child relationships on such training and the possible need to help siblings of retarded children with their feelings and attitudes about the child may call for direct service or consultation by a child-welfare worker.

Many retarded school-age children, particularly those with mild retardation, can profit from direct counseling services to themselves or their parents. Some of them cannot make maximum use of their school experiences because of unfavorable home conditions, emotional disturbances, or hostile community attitudes. In such instances, the child-welfare worker, by virtue of his intimate knowledge of family dynamics, can provide the teacher with valuable insights regarding the child's behavior and learning problems, thus making it possible for her to plan an effective educational approach.

Since the success of a school experience for many children may also depend upon the degree to which knowledge and habits learned in school are reenforced at home, the child-welfare worker may need to serve as a liaison between the school and the family. She can help the family be aware of the teaching methods used, the abilities of the child uncovered at school and requiring continued development at home, and the forms of discipline to which the school has found the child to be most responsive. Not every child requires this special assistance, but where the emotional climate in the home is impeding the child's capacity to learn, the skills of the social worker as a "family specialist" can contribute a great deal.

Retarded adolescents in particular present a challenge to the caseworker. Many of them come to the attention of child-welfare agencies because of delinquent behavior or the need for protective services.

The theory that a person cannot be helped unless he initiates the request for help himself does not hold up in work with retarded adolescents. The social or moral judgment of some of these young people, as well as of their families, may be so impaired as to prevent them from making wise decision, particularly under stress. A child-welfare worker may sometimes need to be a retarded adolescent's superego, setting limits, offering advice, or making direct decisions. Though not made in reference to the retarded, Charlotte Towle's comment regarding "aggressive casework" is relevant:

"We no longer refrain from the use of authority, sometimes actually in the form of judgments as to right and wrong. To the extent that we use this authority in response to the client's need and his incapacity to appraise and regulate himself, rather than out of our own need to be authoritative, we are finding it a helpful measure. We support the client in many instances, more frequently than formerly, with advice and guidance, in response to his capacity to use it, or his incapacity to function without it."[4]

Assuming such responsibility for another person is a weighty obligation. It requires the caseworker to have an understanding of the child's total personality, his special needs, the nature of his defenses, the social attitudes of the community, and his interaction with the environment in which he lives.

Retarded children need to be protected against exploitation, but they also need help in accepting the consequences of their own decisions, if they are able to make decisions and to profit by mistakes. In working with them a child-welfare worker must understand his own attitudes toward mental retardation and must guard against the pitfall of overprotection. He must help parents realize that the development of good judgment does not result from the passive acceptance of failure, but from facing up to unpleasant consequences. Michael F. Grapko has said of normal children: "The persons who succeeds in avoiding unpleasant consequences denies himself the opportunity for learning and growth."[5] This also applies to the retarded.

The child-welfare worker can also help the retarded adolescent in developing good social relationships with the opposite sex, in finding opportunities for vocational training and employment and in budget management. Mildly retarded young adults may also need a social worker's help with the social-adjustment problems of moving into new living arrangements, working with persons with whom they may have little in common, and adapting their living habits to the authority of an industrial setting. Not all of the retarded can make the transition from school to employment, but professional guidance can help many to be assimilated into the general population.

## *Coordination and Research*

Child-welfare workers can also stimulate and participate in community planning and social research in respect to the mentally retarded. There is an urgent need for better coordination and utilization of existing resources in health, education, and welfare under public and private sponsorship. There is also a need for evaluation of ongoing programs, and stimulation of professional and citizens' groups into social action to eliminate gaps in services.

In collaboration with persons of other professional disciplines, child-welfare workers can also investigate the nonmedical aspects of mental retardation so that training and treatment techniques may be based on scientific facts rather than opinion. Greater concern in these areas by social workers and by schools of social work may spread interest in the potentialities of the retarded and provide a basis for more enlightened social attitudes and planning.

Thus, child-welfare workers and other social workers can play an important role in alleviating some aspects of the social component in mental retardation. Although medical research into the possibilities of preventing retardation has made notable progress in determining the causes and possible solutions in certain types of cerebral defect, for the present we must accept the fact that mentally handicapped children will be with us for many years to come. As with other health and welfare problems, social workers must deal with the present situation as well as the future in accordance with the best knowledge and resources currently available.

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[1] American Association on Mental Deficiency, Etiological Classification, Part I, Fourth edition, Statistical Manual, 1957.

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[3] Clark, A. D. B.: A symposium: Social adjustment of the mentally deficient. I. Recent English research. American Journal of Mental Deficiency, September 1957.

[4] Towle, Charlotte: New developments in social casework. Unpublished paper delivered at the annual meeting of Child Welfare Service, Illinois Department of Public Welfare, April 1957.

[5] Grapko, Michael F.: The development of security in children. University of Toronto: The Institute of Child Study, June 1957.

**The greatest inequality of opportunity in this country at the present time lies in the difference in the happiness or unhappiness of the homes from which children come.**

*Eileen Spelman*, Case Conference, *London, October 1957*

# HERE AND THERE

## *Settlement Workshop on Social Change*

Expansion, strengthening, and revitalization of the settlement and neighborhood-house movement to meet needs created by rapid social change were strongly recommended by the participants of the 3-day action-research workshop carried out in mid-February under the sponsorship of the National Federation of Settlements, with funds from Lilly Endowment, Inc. Held at Columbia University's Arden House, Harriman, N. Y., the workshop brought settlement and neighborhood-house people from 25 cities together with consultants from the fields of sociology, anthropology, social work, economics, demography, city planning, and the arts to discuss social conditions challenging settlements today and to establish neighborhood goals in a rapidly changing world.

The conferees sought answers to such questions as: What are some of the major economic and social forces which will affect living conditions in the United States in the coming decade or two? What should be the role of neighborhood centers in the future? How can people engaged in neighborhood work develop new goals for neighborhood-serving agencies? How can attitudes conducive to creative approaches to new social conditions be strengthened among them? What further research is needed to throw light on these questions?

American community life, it was pointed out, has changed drastically in the last quarter of a century. The enormous turnover of population in inner-city neighborhoods has caught most cities unprepared. They now have fewer stable neighborhoods. Although the economic status of city people has improved, their cultural "poverty" is greater.

Population mobility came in for considerable attention. The discussion emphasized that many neighborhoods where settlements now exist have become ports of entry for people who move out as soon as opportunity presents itself and that, therefore, settlement houses and neighborhood centers must work with people on the move, living in crowded conditions and in "pocket ghettos." The participants stressed the need for methods whereby people can be helped more rapidly to become a part of neighborhood life.

They also pointed out that in the families of these neighborhoods fathers and mothers usually are both working except in times of widespread unemployment when they are apt to be the first laid off and the last rehired; that in these neighborhoods schools are crowded and housed in old buildings, with poor equipment; that many children live in unhappy or broken homes; that many of them are part of so-called "hard-core, multiproblem" families.

The discussions revealed a variety of ways in which the settlements and neighborhood centers are trying to help families of such neighborhoods: through neighborhood councils; through intergroup projects in an effort to help the "hard-to-reach" youth groups; through short-term casework with individual families; through social groupwork to help meet needs of individuals through the group; through educational TV programs; through special work with handicapped groups, such as the mentally retarded, the blind, the aging; through family-life educational programs; through housing programs; and through arts and crafts.

The opinion predominated that in this day of changing needs the settlement because of its proximity and accessibility is indispensable as an agency for sorting out the troubles of people and providing some services not otherwise available to them. As one settlement worker said, "When they need you most they need you near."

The participants underscored the validity of the concept of neighborhood for many people, particularly for those who are poor or troubled. They identified the substance of a neighborhood center as personal relationships. By providing such relationships, they said, the center helps to give people roots and a sense of identification. Thus it serves as an important mechanism for communication within a neighborhood.

A sense of urgent need for more factfinding and research emerged during the workshop. The participants suggested a number of areas for research, relating to direct services, social movement and development, and recruitment and training of staff. In connection with direct services they identified a need for research on the "multiproblem" family, the adolescent, and the newcomer. Some aspects of social movement and development suggested for research were citizen participation, neighborhood organization, citywide or metropolitan organization, cultural bridging responsibilities, medical-care organizations, and intergroup relations.

The workshop, which was led by Wilbur J. Cohen of the University of Michigan, was planned to provide direction to the Federation and its affiliates in designing future program.

*—Mildred Arnold*

## *White House Conference*

Late in March the House passed the appropriation bill containing the administration's budget request for 1959 for $150,000 for staff and other expenses related to the 1960 White House Conference on Children and Youth.

March 1960 has been tentatively set as the time for the conference. In the near future a director for the conference planning will be named as will the members of a Presidential Advisory Committee.

In its role as initiator of conference planning the Children's Bureau has been gathering suggestions, to be passed on to the President's Committee, during the past year from professional and lay groups especially called together for the purpose or otherwise convened. The first of these meetings, held last September, was of an interim advisory group of 15 persons appointed by the 1956 Joint Conference on Children and Youth, sponsored by the Interdepartmental Committee on Children and Youth, the Council of National Organizations, and the National Council of State Committees on Children and Youth. In February 1958 a small group of physicians and one of educators, speaking as individuals, made suggestions in 1-day meetings held in the Children's Bureau offices. Three organizations holding regular meetings in March devoted special sessions to the subject. These were the Education-Recreation section of the National Social Welfare Assembly, the Association of State Maternal and Child Health and Crippled Children's Directors, and the Joint Conference on Children and Youth.

All these groups strongly advocated that the Conference concern itself with ways of strengthening family life. Among the many specific questions suggested for conference scrutiny were:

How can families be helped which never set down their roots in any community? How can the planners of public and private housing be induced to take into account the needs of children and adolescents for a good home life? How can children and young people be encouraged to become both cooperative and independent? How can the "growth and development of parents" be nourished without undermining parents' self-confidence?

How can our education systems be geared to modern knowledge in regard to the effects of human relations on learning? How can the schools meet the needs of children who have special needs and still stimulate the creative potential in all children? How can children be helped to develop the attitudes, insights, and skills essential for international understanding? What is the teacher's function in our present culture?

Among areas suggested for factfinding were: accidents and poisoning; environmental contamination by man; perinatal problems; infections; prematurity; genetic and psychological factors in child development; health supervision of children from preschool age to maturity; and the problems and needs of adolescents.

At the 1958 Joint Conference on Children and Youth, Katherine B. Oettinger, Chief of the Children's Bureau, outlined the suggestions about the White House Conference received to date and, pointing out that conference attendance must be limited to 3,500, posed, among other questions, the following:

How can youth and parents, as parents, effectively participate in all stages of the conference? How can planning include both factfinding and action—at National, State, and local levels? How can widespread support for the conference be enlisted among persons who, because of space limitations, cannot be invited to participate in the meeting in Washington? How can democratic procedures and cooperative goals be assured?

In the ensuing discussion youth delegates to the Joint Conference urged that 30 percent of the delegates to the White House Conference be young people, two-thirds of these being "youth" or teen-agers, and one-third young adults. Another suggestion was for the appointment of an intergroup relations advisory committee to consider the Conference's possible contribution to the understanding of the impact of prejudice and racial discrimination on the growth of the child.

## UNICEF

The Executive Board of UNICEF at its annual meeting in March decided to explore the area of aid to children in institutions and day-care centers to see if it is a suitable program area for UNICEF aid. Under the action, UNICEF is authorized to seek the help of the United Nations Bureau of Social Affairs and the maternal and child-health staff of the World Health Organization in developing a possible program to be ready for consideration at the 1959 meeting of the Board. If this type of aid were then accepted in principle, demonstration projects of a pilot nature might subsequently be considered by the Board for UNICEF support.

In making the proposal the United States representative, Katherine B. Oettinger, Chief of the Children's Bureau, said that the most universal method of care for children outside their own home is in congregate or specialized residential institutions, and that many infants and preschool children of working mothers are being cared for in day nursery and crèche programs in countries experiencing industrialization or otherwise needing the labor of women.

Pointing out that the kind of care these children get varies tremendously in both types of services, she added:

"The dangers of physical and mental health are known to be very great for children living in institutions, particularly for long periods of time. In some countries an effort is made to develop adoption and foster family care for younger children, but in many countries institutional care will be the only means of providing for dependent and neglected children for many years. . . . There are many ways institutional care can be modified and improved so that it provides more adequately for children's physical, mental, and emotional needs; so that some of the benefits of home life can be preserved; and so that the child can be better prepared to enter into community life as an adult."

## Physical Fitness

A plan for community action for promoting fitness in young people through the encouragement of physical activity has recently been released by the President's Council on Youth Fitness. Based on the premise that youth, being "naturally physically active," will respond to opportunities to plan and participate in sports and other physical activities, the statement urges communities to: increase, where needed, the number and variety of existing sport activities; emphasize health and nutrition education; make greater use, for physical activities, of existing public and private facilities, such as schools, recreation centers, and parks; provide high-quality adult leaders in sufficient number for the fitness programs.

## Against Polio

In view of new evidence that children 1 to 4 years of age are more susceptible to paralytic polio than those of any other age group, the Public Health Service is urging special efforts to have children under 5 years of age vaccinated against the disease. The American Academy of Pediatrics and the American Academy of General Practice are joining the campaign to protect the under-5 age group.

Preliminary figures compiled by the Public Health Service's Communicable Disease Center show that in 1957 1-year-old children had the highest attack rate for paralytic polio—5.7 per 100,000 children a year old. The next highest rate—5.5—was among 2-year-olds. For all children through the age of 4 the rate averaged 4.4, compared with 1.4 for the 5-through-19 age group and 0.8 for persons 20 through 39.

The figures show also that the large majority of paralytic cases occurred in nonvaccinated persons.

The campaign is part of a larger one, in which the Public Health Service, the American Medical Association, the National Foundation for Infantile Paralysis, and other groups are promoting vaccination of all persons through the age of 40 with the Salk vaccine.

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The National Foundation for Infantile Paralysis recently granted funds totaling more than $1 million for poliomyelitis research and treatment. Part of the grants for treatment will be used to establish two new poliomyelitis centers at universities.

Among the projects covered by the research grants are work on a new surgical technique to halt scoliosis, a curvature of the spine; studies of swallowing, respiration, and speech after an attack of bulbar poliomyelitis; and electric activity of the brain in children with contagious diseases.

## *Mental Health*

A number of States enacted legislation in 1957 to increase State and community mental-health programs and services for emotionally disturbed and mentally retarded children.

Four States—California, Minnesota, New Jersey, and Vermont—passed laws providing grants-in-aid to localities for community mental-health services such as mental-health clinics, services for emotionally disturbed and mentally retarded children, rehabilitative and aftercare programs, and public education in mental health.

Laws authorizing counties to levy taxes or to appropriate funds for supporting local mental-health centers or clinics were passed by Iowa, Kansas, and South Dakota.

Arkansas, Nebraska, and Texas authorized construction of new institutions for care and treatment of the mentally retarded. Idaho and Minnesota made it mandatory for local school districts to provide instruction for handicapped children. The State of Washington authorized establishment of a diagnostic and training center for the mentally retarded and a research and treatment center for emotionally disturbed children.

Minnesota authorized a residential treatment center for emotionally disturbed children; New York, an institution for research in mental retardation. California authorized its Youth Authority to establish a special program of intensive treatment in two institutions for juvenile delinquents.

North Dakota's legislature provided for training stipends for psychiatric personnel for the mental-health agencies of the State.

## *Health Studies*

Factors in each maternal death in four regions in California are being analyzed as a step toward safeguarding pregnancies and saving mothers' lives. The investigation, which was begun in August 1957, is being carried on jointly by the State medical association, the State department of public health, and local health departments in those regions.

Before beginning to collect the data a committee of the association defined four regions in the State in which the number of maternal deaths per year was about equal, and appointed a study committee in each, including an obstetrician, an anesthesiologist, a public-health physician, and a pathologist.

Whenever a local health officer in one of these regions files a death certificate mentioning pregnancy, he sends copies to the regional study committee. An obstetric consultant employed by the State health department then interviews the physician who attended the mother who died; with the attending physician's permission he also reviews her hospital record. The regional committee reviews all the factors involved in the death from the point of view of future efforts to prevent such deaths.

Statistical services for the study are provided by the State department of public health.

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The U. S. Public Health Service, in cooperation with the Insular Department of Public Health, is studying Puerto Rican adults found with untreated oral clefts. A pilot study, made in Puerto Rico last June, suggested that much valuable knowledge about the management of oral clefts could result from the study of untreated cases at maturation. An intensive case-finding effort is now underway and the Public Health Service team will begin their main study of these cases next May in Puerto Rico.

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The first nationwide study of reactions to the principal antibiotics shows a substantially greater incidence of reactions to penicillin than to other drugs in this group, according to the Food and Drug Administration, Department of Health, Education, and Welfare, which made the study.

One-third, or 1,070, of the reported reactions to all antibiotics were classed as life-threatening; of these, 900 were reactions to penicillin.

Though case histories indicate that physicians have not been using penicillin indiscriminately, the FDA suggests that before it is administered to a patient there should be a clear-cut indication of need. It is not possible, the FDA noted, to determine absolutely that an individual will or will not suffer a reaction to the drug.

The study covered the period from the latter part of 1953 to early 1957, and showed that during this period serious reactions to penicillin have been increasing each year. Copies of the complete study report will be made available to the medical profession.

## *Inservice Training*

With a grant from the Rockefeller Brothers' Fund the American Public Welfare Association is conducting a 3-year project to help State and local public welfare agencies in developing their social-service programs. As part of the project, two training institutes have already been held, one in January 1958 on the objectives of public administration and the leadership role of the public welfare administrator, and one in March on preventive and protective services for children. Future institutes will take up such subjects as medical-care administration, staff-development program objectives, research for now and for the future, and the county department of welfare as a service agency. As part of the project the association is also planning to publish material for use in program development.

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Last February the New York City Board of Education and a voluntary agency, the Jewish Child Care Association of New York, initiated a 15-session seminar for employees of the city school system who teach in institutions for dependent, neglected, and emotionally disturbed children. Thirty-five teachers have been enrolled.

The seminar includes discussion of the definition of emotional disturbance in children; the components of a program for institutional treatment; the circumstances that lead to placement of children in institutions and other types of placement; the use of psychological and remedial services in overcoming learning blocks; the psychological development of the child and the origins and signs of deviant behavior; the role of cottage parents and recreational workers in institutional treatment; and the place of the school in the treatment program.

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The National Council for the Gifted, an organization formed last November in West Orange, N. J., has announced plans to work with educational systems in developing programs from nursery school through college for children who have unusual ability in specific areas. The organization will focus on encouraging business concerns, industries, and the professions to cooperate with schools in developing educational activities—in school and elsewhere—for such boys and girls; to help prepare teachers for work with the gifted; to encourage research and experimentation in the education of the gifted.

## *Radiation*

A National Advisory Committee on Radiation was recently appointed by the Surgeon General of the Public Health Service to advise him and the Service's new Division of Radiation on further development of programs dealing with public-health aspects of radiation from all sources. Present activities of the Service, planned to safeguard the public against the hazards of radiation, include: helping the States to develop programs for reducing the amount of radiation to which people are exposed; training professional personnel for health work concerned with radiation; basic research on the effects of radiation on man; study of public-health methods for monitoring the amount of radiation in such media as soil, milk, water, and air; developing methods for reducing these amounts; and epidemiological studies of radiation-induced disease.

## *Juvenile Delinquency*

The Senate, by a resolution enacted January 29, 1958, has authorized expenditure of $75,000 for investigation of juvenile delinquency in the year ending January 31, 1959, by the subcommittee to study juvenile delinquency, of the Committee on the Judiciary (S. Res. 237). According to the report that accompanied the resolution, the subcommittee plans to concentrate on the following areas: training schools for delinquents; policies of the Armed Forces with regard to inducting former delinquents; a community plan for handling delinquency problems, produced as a result of hearings held in New York City; probation, parole, and juvenile courts, including violation of the rights of children in juvenile courts; and methods of dealing with delinquent and incorrigible children in public-school systems. The subcommittee will conduct hearings on legislation coming under its jurisdiction (Report 1206).

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The Community Welfare Council of Minneapolis, Minn., is carrying on a study that will continue for at least a year to find out whether the social adjustment of members of delinquent youth groups is appreciably improved through the efforts of "floating workers" from social agencies; and whether the efforts of such workers improve the attitudes of significant individuals in the delinquents' neighborhoods.

Two neighborhood houses are collecting information on changes that take place in the actions of the members of six delinquent groups with regard to disorderly conduct, offenses against property and against persons, and traffic offenses. Data on the boys and girls—13–17 years old—will be gathered concerning their conception of themselves and of others; their evaluation of their school, family, and community; and their employment records. Information will be sought on group atmosphere and on organization of delinquent groups and their activities. Selected persons in the neighborhoods, such as churchmen, businessmen, and educators will be asked about some aspects of change in the community climate.

Six other delinquent groups, living in the same general kind of area as the groups being studied, but some distance away, are serving as controls.

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As a step toward helping training schools for delinquent children further evolve from custodial to treatment institutions, the Children's Bureau, with the Rutgers University Graduate School of Social Work and three associations of training-school administrators, jointly sponsored a workshop held at New Brunswick, N. J., March 30–April 5, 1958, to examine administrative problems arising from inservice staff training in institutions for juvenile delinquents. The workshop, which grew out of a similar 5-day workshop held in April 1957 with help from the American Legion Child Welfare Foundation, was supported by a grant from the Ford Foundation.

The three associations participating as sponsors were: the National Conference of Superintendents of Training Schools and Reformatories, the National Conference of Superintendents of Girls' Training Schools, and the National Association of Training Schools and Juvenile Agencies.

As with last year's workshop, which was reported in a Children's Bureau publication, "Staff Training for Personnel in Institutions for Juvenile Delinquents," a report of this year's is expected to be issued.

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A 3-year study of problems and practices in institutions for delinquent children is being carried on by the New York School of Social Work's research center with a grant of $130,000 from the Ford Foundation. The purpose of the study is to discover the effects of various types of human relationships on rehabilitative efforts, especially: (1) How the children's own codes of behavior and social structure affect their participation in the institutional activities; (2) how the points of contact between the children's life in their own social structure and in the institutional program can be used to influence their social concepts; (3) how staff relationships and structure affect the children; (4) how institutional programs can be affected by external pressures; (5) how social changes can be made in institutions when the children's needs require them.

Codirectors of the study are Lloyd E. Ohlin and Richard A. Cloward.

## *Proxy Adoptions*

Because of a great increase in recent years in adoptions by proxy of children from overseas, the Child Welfare League of America and the International Social Service, American Branch, are jointly undertaking a preliminary survey of the extent of this practice and the problems it has created.

In a proxy adoption, a foreign child while still in his own country becomes the legal child of adoptive parents in the United States. With few exceptions the adoptive parents have not seen the child before he is brought here. No requirement exists for a determination of the fitness of the parents by a court in the United States, or for investigation of them by an authorized social agency. Because the adoptive parents do not appear in the foreign court but are represented by a proxy, it is possible for them to know little or nothing about the child they are adopting.

Through the survey information will be gathered from member agencies of the Child Welfare League and from State public welfare agencies about proxy-adopted children and their adoptive families, in an effort to determine the need for new Federal legislation or for a broader study of what is happening to these children.

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Last November the executive committee of International Social Service meeting in Paris adopted a resolution pointing out to national authorities responsible for child welfare and the proper bodies of the United Nations the possibility that adoption by proxy may violate the rights of the child. The resolution asserted that ISS experience with adoptions had demonstrated the importance of "the most careful social study possible, particularly when children are adopted outside their country of residence."

The ISS's American branch has recently issued a statement identifying four safeguards in adoption procedures which are lacking in proxy adoptions: Careful preparation for termination of parental rights; social-agency determination of suitability of the new family and home for the child; social-agency determination of the child's adoptability; a living-together period for family and child before adoption is final. The statement is accompanied by 16 brief case stories of proxy adoptions, all of which ended in tragedy.

## *WHO Assembly*

The first meeting of the World Health Assembly, the governing body of the World Health Organization, to be held in the United States since the establishment of WHO in 1948 is convening at the end of May in Minneapolis, Minn. Among the Director General's proposals for WHO's 1959 work to be considered are WHO's program in the peaceful uses of atomic energy, including cooperation with the International Atomic Energy Agency. For 2 days before the business meetings the Assembly will observe WHO's tenth anniversary with a special session reviewing the Organization's work.

## *Mental Retardation*

As a step toward sharing information on operation and management of clinics for mentally retarded children, State directors of maternal and child-health services and clinic directors of special projects for the mentally retarded met in Washington March 24–25 at a conference called by the Children's Bureau. Fifty States and Territories were represented among the 124 persons present.

Participants described methods used in some of the programs to tabulate clinical data and discussed possible efforts to extend such procedures to all of the clinics. Consideration was also given to the possibility of agreeing on a standard system of nomenclature and classification of types of mental retardation.

Suggestions on clinic management made by the conferees related to, among other subjects, waiting lists and priorities; evaluation of a child's condition; interpretation of the condition to parents; and research activities.

Among many clinic needs expressed by the discussants, the one most emphasized was the need for a clearinghouse to share records of unusual cases; review and abstract literature, provide lists of available publications and information on grants, study courses, and meetings; develop more adequate clinical record forms; and possibly to coordinate study projects. The group decided to set up committees to explore further the needs of mental-retardation clinics and to suggest ways of fulfilling them.

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Two companion reports surveying research into the causes of mental retardation have been issued recently under sponsorship of the National Association for Retarded Children. One, written by a physician, reviews research on physical factors that lead to damage of the nervous system, preventing development of normal intellect; the other, by a psychologist and an anthropologist, examines studies concerned with the influence of environment on mental development.

The report on studies of physical causes, prepared by Richard Masland, M. D., summarizes the results of investigations of genetic and other defects existing before birth (the cause of an overwhelming majority of cases of retardation); of injuries to the nervous system around the time of birth; and of diseases of infancy and childhood. It notes that with some disorders a baby may be born susceptible to some condition that will affect his mentality only when the condition is combined with unfavorable environment factors.

Recognizing the contribution of psychiatrists to the management of the mentally retarded, the author urges that the medical profession as a whole take more interest in establishing multidisciplinary programs for retardates. Such programs are lacking, he says, partly because both the public and the profession feel that the mentally retarded are not the concern of the physician. He attributes this attitude to the "undeniable fact" that in most cases of retardation medical treatment has little to offer, a fact which emphasizes the importance of dealing with the social and educational problems, especially those of the less severely retarded.

The report recommends that new training schools for mentally retarded children be placed near university medical centers and that medical schools include diagnostic facilities for the mentally retarded.

The report on the influence of environment on retardation was prepared to encourage social scientists to view mental retardation as an important research area, according to the authors, Seymour B. Sarason, Ph. D., and Thomas Gladwin, Ph. D. Stressing the importance of social and cultural factors in mental development, this report recommends a number of steps toward finding the causes of retardation. Among the measures are: cross-cultural research to test hypotheses regarding genetic, dietary, metabolic, and other factors in mental development; longitudinal studies of the familial and social milieu in which retarded children live; and studies to identify the mental ability needed for minimally adequate life in the community.

The two reports, first published separately, will soon be available in a joint edition from the National Association for Retarded Children.

# IN THE JOURNALS

## *Social Agencies and Courts*

The juvenile court from the point of view of a social worker and of a judge is discussed in two articles in *Child Welfare* for March 1958. ("The Social Worker and the Court," by Naomi Grossman, supervisor of court service for the Jewish Board of Guardians, New York City, and "The Court's Authority," by Henry G. Sweney, President Judge, Delaware County Court, Pa.)

In her article Mrs. Grossman urges social caseworkers to recognize the court for what it is—a public judicial agency, not a casework agency, though she notes that the court's work may be the first step in getting help to families "so caught in the morass of poverty, deprivation, and dependency that they cannot move forward." Social workers, she says, must learn that the court is neither a treatment resource nor a bugaboo.

Judge Sweney describes cooperation between the judge and social agencies in treating two kinds of cases: families still living together but functioning poorly, and broken families requiring temporary or permanent placement of children. In both kinds of cases, the author says, he finds it important to make clear to the family the legal rights and responsibilities of the parents and the power of the court to remove the children. He finds that such understanding is likely to lead to success when the caseworker tries to help the parents plan for the children's future.

## *Court Commitment*

Most of the chilren brought before juvenile courts do not need the total rebuilding job offered by correctional institutions, says Thomas D. Gill in the January 1958 issue of the *National Probation and Parole Association Journal*. Rather, he maintains, the vast majority need only the help that can be given through probation. ("When Should a Child Be Committed?")

The author, who is judge of the Connecticut State Juvenile Court, defines the child who needs removal from the community as the one whose behavior is persistently antisocial and seriously affects other people, who shows continuing defiance to adult authority, and who has been unable to benefit from probation. Many such children can be helped by a modern correctional school, the author says, but if their difficulties stem from inner tensions they may belong in special treatment centers for the emotionally disturbed. He also points out that some children who are psychotic, mentally retarded, or otherwise organically damaged should not be placed in a correctional school because such a school cannot help them properly and because their presence in the school would impede its efforts to help the children who belong there.

If facilities are not available to take care of children who need special care the juvenile-court judge should crusade to obtain them, the author maintains.

## *Vs. Rheumatic Fever*

A low-cost program for reducing the incidence among school children of rheumatic fever and other diseases that follow streptococcic infection is described in two articles published in the *Journal of the American Medical Association* for March 8, 1958. ("The Casper [Wyo.] Project—an Enforced Mass-Culture Streptococcic Control Program: 1. Clinical Aspects; 2. Technical Aspects.") The article on clinical aspects of the program is by Brendan Phibbs, M. D., chairman of the rheumatic-fever control committee of Natrona County Medical Society; Donald Becker, M. D., pathologist of the county hospital; and seven other physicians. The technical aspects are described by Dr. Becker, Dr. Phibbs, and Charles Lowe, M. D.

The program, which is carried on in the primary grades of all the schools in the city, is reported as follows: Every school day teachers refer all children who seem ill or who complain of sore throat or a cold to volunteer workers trained to inspect them for symptoms of streptococcic infection and to take throat cultures of suspected cases. Those whose cultures are positive are excluded from school until they have been treated by their family physicians at least 24 hours. Free penicillin is available from the State department of health to families unable to pay for it. Every private physician in the county has responded "vigorously and intelligently" to the demands of the program, the authors note.

Figures cited show that the program has produced a significant lowering of the incidence of streptococcic infection among this group of more than 6,000 children and appears to have reduced the incidence of new cases of rheumatic fever and acute nephritis.

## *Parents of Epileptic Children*

Three members of the staff of the seizure clinic of the Los Angeles Children's Hospital have for the past 3 years been meeting regularly with groups of parents to answer their questions and otherwise help them to lessen the tensions arising from their child's condition. An account of these meetings, reported by the pediatrician, the psychologist, and the social worker who conduct them, is published in the March 1958 issue of the *Journal of Pediatrics*. ("Group Sessions for Parents of Children With Epilepsy," by Gaston J. Baus, L. LaVergne Letson, and Edith Russell.") The course consists of five weekly sessions of an hour or an hour and a half. The group is kept small enough to make round-table discussion and interruptions possible.

At the first two sessions the pediatrician, who is also an epileptologist, gives the parents medical information: he describes the different kinds of seizures and their frequency and duration and teaches the parents how to take care of a child during a seizure. He discusses the principles of treatment of epilepsy, emphasizing that the medications used are not habit forming. The third and fourth sessions, conducted by the psychologist, are aimed at helping the parents with emotional problems, such as the fear that correcting the child will bring on a seizure. The social worker, at the final session, focuses on the child's social relationships and tells the parents about community resources such as school programs for epileptic children, camp facilities, and groups interested in the disease.

# BOOK NOTES

THE LOUISVILLE STORY. Omer Carmichael and Weldon James. Simon & Schuster, New York. 1957. 169 pp. Cloth, $3.50; paper, $1.

How the schools of Louisville, Ky., integrated their Negro and white pupils successfully into their classes is described in this book by the city superintendent of schools and a member of the editorial staff of a local newspaper.

Factors in the success of the change are listed as: (1) A long period of good racial relations and interracial adjustment before desegregation of the schools began; (2) prompt and clear-cut acceptance of the Supreme Court's decision in the segregated school cases as the law; (3) immediate announcement after the Court's "how and when" ruling that it would be carried out without delay or subterfuge; (4) preparation of pupils, teachers, and the community for the coming changes; (5) full cooperation of city and county officials and coordination of the city's plans with the county's; and (6) a friendly press.

Among the features of the desegregation plan adopted by the board of education 9 months before the schools' opening day in September 1956 the book lists: Every school in the city and every grade—kindergarten through adult classes—to admit both white and Negro pupils; new school districts to be formed, without regard to race and without unnatural boundaries; each school to serve the children in its area as conveniently as possible, without excessive travel for any child; parents of each child to be informed in writing of the school or schools where their children belong; transfers to a school preferred by a parent to be granted insofar as possible.

PSYCHOTHERAPY OF THE ADOLESCENT. Edited by Benjamin Harris Balser. International Universities Press, New York, 1957. 270 pp. $5.

In this book a number of psychiatrists present various aspects of treatment of adolescents in difficulty. They discuss, for example, psychotherapy of adolescents in psychiatrists' private practice; at school; in clinics; as inpatients in hospitals; and in several combinations of these, such as at school plus inpatient hospital treatment. The book also presents a verbatim 20-minute tape-recorded interview between an 18-year-old boy and a psychotherapist, annotated with interpretive comments by the therapist. One chapter, by a school principal, presents a schoolmaster's view of the normal adolescent as a "somewhat disturbed person requiring at least a mild and continuous therapy from parents and teacher."

NEW UNDERSTANDING OF LEADERSHIP; a survey and application of research. Murray G. Ross and Charles E. Hendry. Association Press, New York. 1957. 158 pp. $3.50.

In this book the authors, both university officers and former professors of social work, discuss types of leaders and theories of leadership, summarize a large number of research studies on the nature and meaning of leadership, and offer a tentative program for developing leaders.

THE PLACEMENT OF ADOPTIVE CHILDREN. J. Richard Wittenborn, assisted by Barbara Myers. Charles C Thomas, Springfield, Ill. 1957. 189 pp. $4.75.

Reporting on a follow-up study of a number of families with adopted children the authors, a professor of psychology and a research specialist in psychology and sociology, recommend several steps for the improvement of adoption agency services.

The authors address themselves to two questions: (1) How accurately and in what respects can the Yale Developmental Examination of infant behavior be employed to predict future development for adoptive children? (2) What characteristics of adoptive placements may be shown to be correlated with characteristics of adoptive children?

In regard to the first they report that their data do not indicate any useful predictive value for that examination. In regard to the second, they produce comparative data on the Binet I. Q. scores and such traits of the child as "aggressiveness" or "maturity quotient" in relation to the background of the child's true parents, similarities between adoptive parents and adoptive children, "matching" of adoptive parents and children, independent and social-agency placements.

In their conclusion the authors recommend methods for a long-term and widespread investigation to determine the relative importance of various aspects of child care for an adopted child.

NO AND YES: On the genesis of human communication. René A. Spitz, International Universities Press, New York, N. Y. 1957. 170 pp. $4.

This book reports on a section of a continuing study of the genesis of communicative efforts in infant development. It deals with the inception of semantic and symbolic communication, the beginnings of thought processes, and concept formulation. The entire study is psychoanalytically oriented, its purpose being to substantiate through research some of Freud's most basic theoretical formulations.

DELINQUENCY; sickness or sin? Richard V. McCann. Harper & Bros., New York. 1957. 179 pp. $3.

This book is based on a study begun at the Harvard Divinity School in 1954 to determine what greater role religion might play in preventing juvenile delinquency. A seminar in delinquency was organized. As an integral part of this, theological students went to detention centers, clinics, probation departments, and other agencies to work directly with delinquent youth and get to know them.

To obtain comparable data about each delinquent youth an interview guide was developed which could be used flexibly and informally by students to discover whom they admire, the degree of their emotional outreach, and the nature of their goals. It was found that most delinquent boys and girls interviewed either lacked any self-concept or had an inadequate or distorted self-image. This inadequacy was traced to the absence of meaningful adults in their lives. This was the main clue pursued by the study staff to determine why the traditional moralistic church approach often fails to reach children in trouble or to prevent delinquency. Suggestions for action by clergy, parents, and laymen are included.

CHILDHOOD AND ADOLESCENCE; a psychology of the growing person. L. Joseph Stone and Joseph Church. Foreword by Otto Klineberg. Random House, New York. 1957. 456 pp. $6.50.

Planned "to convey a more accurate understanding of children," this textbook, by two members of the faculty of Vassar College's Department of Child Study, is chiefly devoted to examination of facts concerning psychological development of the child from conception through adolescence. It also describes some deviant forms that development may take and some of the disturbances of normal psychological functioning that may arise during the growing years. Finally, it defines the field of child study and shows how such study has evolved, notes some of the methods that have been used in finding out about children's development, and sets forth some of the problems that need to be solved.

THE YOUNG HANDICAPPED CHILD; educational guidance for the young blind, cerebral palsied, and deaf child. Agatha H. Bowley. With a section on The Young Deaf Child, by L. Gardner. E. & S. Livingstone, Edinburgh and London. 1957. 128 pp. Available from the Williams & Wilkins Co., Baltimore. $3.50.

Emphasizing development of initiative and independence in the handicapped child, this book offers concrete suggestions to parents and teachers of such children.

LOGIC AND PSYCHOLOGY. Jean Piaget. Introduction by W. Mays. Basic Books, New York, N. Y. 1957. 48 pp. $1.50.

This book is based on three lectures delivered in 1952 at the University of Manchester in which the author shows how the techniques of symbolic logic may be applied to the study of the intellectual development of the child. It is a technical research publication directed specifically to highly trained specialists in child psychology and related fields. An explanation of Piaget's system of symbolic logic is contained in the introduction.

CHILD CARE AND TRAINING. Marion L. Faegre, John E. Anderson, and Dale B. Harris. Eighth edition, revised. Prepared under the auspices of the University of Minnesota Institute of Child Development and Welfare. University of Minnesota Press, Minneapolis. 1958. 300 pp. $3.

This eighth edition of a book first published in 1928 has been revised in the light of recent research and current theory about child development. It includes two new chapters: on accidents and on personality adjustment.

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# GUIDES AND REPORTS

MENTAL GROWTH AND PERSONALITY DEVELOPMENT: A LONGITUDINAL STUDY. Lester W. Sontag, Charles T. Baker, and Virginia L. Nelson. Monographs of the Society for Research in Child Development, Vol. 23, Serial No. 68, No. 2. 1958. Child Development Publications, Purdue University, Lafayette, Ind. 143 pp. $3.

Reports on changes in mental ability in 140 children, and on personality, familial, and physical factors associated with such changes.

TEN MILLION AND ONE; NEUROLOGICAL DISABILITY AS A NATIONAL PROBLEM. Preface by Leona Baumgartner. Paul B. Hoeber, New York. 102 p. $3.50.

A report of a conference sponsored by the National Health Council. Includes discussion of the cost of neurological disability to society and to the individual; diagnosis and treatment of the disabled person; development and dissemination of knowledge about this type of disability; preparation of the patient for mature existence; and research.

A COMPARISON OF BRAIN-INJURED AND NON-BRAIN-INJURED MENTALLY RETARDED CHILDREN ON SEVERAL PSYCHOLOGICAL VARIABLES. James J. Gallagher. Monographs of the Society for Research in Child Development, Vol. 22, Serial No. 65, No. 2. Child Development Publications, Purdue University, Lafayette, Ind. 1957. 79 pp. $2.50.

Reports on a study in which matched groups of 24 brain-injured and 24 familial mentally retarded children were compared on measures of perception, learning aptitude, intellectual scatter, language development, quantitative ability, and personality characteristics. While differences were found between the groups primarily on personality variables, the range of problems encountered casts doubt, according to the author, on the wisdom of treating the brain-injured as a homogeneous group either for program planning or research.

SCOUTING WITH HANDICAPPED BOYS. Boy Scouts of America, New Brunswick, N. J. 1957. 64 pp. 75 cents.

Describes how boys can participate in Scout activities, even though blind, crippled, deaf, mentally retarded, or otherwise handicapped.

STEPS FOR TODAY TOWARD BETTER MENTAL HEALTH; pointers to action for all who give health services. Report of the 1957 National Health Forum. National Health Council, 1790 Broadway, New York 19, N. Y. 1957. 118 pp. $1.50.

Includes discussions on: the promotion of mental health in the family, in the schools, and in industry; in-service training in good mental-health procedures for health workers; and community self-study of mental-health needs and procedures; and an analysis of the causes of mental illness by a panel brought together by the Joint Commission on Mental Illness and Health.

# READERS' EXCHANGE

## OHLIN: *Treatment implications*

Dr. Ohlin dramatically demonstrated but left unstated what is perhaps the most significant contribution of his article: *Diagnoses of "personality disorders" must be made in organizational rather than individualistic terms.* ("The Reduction of Role Conflict in Institutional Staff," by Lloyd E. Ohlin, CHILDREN, March–April 1958.)

Certainly it has been traditional to assume that "uncooperative" behavior among institutional staff members is a personal characteristic of the individual exhibiting the behavior. In institutions for treatment personnel policies are almost always based on this assumption. If a nonprofessional worker does not cooperate with the professional staff it is common, for example, to diagnose him as a "rigid," "punitive," "neurotic," or even "sadistic" personality. Such diagnoses are followed by efforts to change him through education and therapy, or by dismissal.

Professor Ohlin has effectively shown that an alternative theory of personality calls for quite different kinds of diagnoses and, consequently, quite different personnel policies. The personality theory he uses has long been buried under an avalanche of variations on Freudian theory. It is time to dig it out. Fundamentally, and in much oversimplified form, the theory maintains, in the words of Dorwin Cartwright (*Human Relations*, 1951), that "how aggressive or cooperative a person is, how much self-respect or self-confidence he has, how energetic and productive his work is, what he aspires to, what he believes to be true and good, whom he loves or hates, and what beliefs or prejudices he holds—all these characteristics [are] in a real sense the properties of groups and of the relationships between people."

Dr. Ohlin's article shows conclusively that many traits exhibited by individual staff members are properties of the *organization*, not of the person in question. From this observation, it follows logically that if the traits are to be changed the organization, not the person, must be made the object of modification. This is what was done in the experiment the article describes, the first of its kind so far as I know; and it worked.

We should no longer talk about "sadistic" men seeking out jobs as policemen or institutional workers. Rather, we should ask what organizational structures are present in police departments and institutions to produce action which we define as sadistic. The essential notion, again, is that one who is involved in an organization that "owns" certain kinds of behavior will exhibit those kinds of behavior.

There are also implications for dealing with the inmates, not the employees, of the institutions. How easy it is to attribute a fight between two inmates to personal traits such as "aggressiveness," "latent hostility," or "hot temper." Alternatively, we should ask: "What is there about the institutional organization which produced a fight?" Once this is answered we can ask, further, whether this can be changed and, significantly, whether it is desirable to change it. Conceivably, organizational modification to eliminate the fights could have as its consequence the elimination or modification of other conditions which we hold dear.

There are implications, too, for theories of delinquency and crime causation. By far the most popular notion in this area in that delinquency is a personal trait, "owned" by the delinquent. It is usually viewed as a symptom, to be sure, but as a symptom of something belonging to him, not to his group (organization). However, we might view delinquency as the property of groups in the same way that we view institutional staff attitudes as the properties of organizations. It would follow that rather than providing therapy of a type designed to modify individual personalities we would use therapy designed to modify the groups owning the behavior the delinquent is exhibiting.

*Donald R. Cressey,*
*Chairman, Department of Anthropology and Sociology, University of California, Los Angeles.*

### *Preparation for change*

In his article on role conflict in cottage staff, Dr. Ohlin touches upon the key problem of institutional administration.

Unless institutions come to grips with the conflicts and anxieties of cottage staff, they lose all possibilities of communicating treatment concepts. Role conflict is not only engendered by a correctional organization's changing from a custodial to a treatment orientation, as described by Dr. Ohlin, but is inherent at all institutions in the cottage-parent role itself.

Cottage staffs come to institutions with fixed ideas concerning eating, grooming, washing, cleaning, use of language, and other elements of behavior. Confronted with delinquent standards, the tendency for the staff member is to react in terms of his own life experience. Clinical considerations which call for individual differentiation are apt to create conflict and anxiety in him in direct proportion to the strength of his fixed ideas. A cottage parent whose standard for cleanliness is two baths a day can become quite upset when faced with the suggestion that for a particular girl or boy a shower every 2 days might be all that could be expected.

It was primarily to help cottage parparents with such problems through a close supervisory relationship that the new treatment structure described in Dr. Ohlin's article was organized at the New York State Training School for Girls. In analyzing this experiment, Dr. Ohlin says: "The relatively untroubled smoothness with which the new integration (of casework and home life departments) has occurred suggests that the basic accommodations which formerly existed between the girls' informal organization and the official system have not been materially altered."

I would like to make a few comments in regard to this statement:

1. Dr. Ohlin is incorrectly assuming that the control problems described to him as having existed in the school in 1953 had continued until eliminated by the introduction of the new integrated program in 1956. His hypothesis would be valid if the program had been introduced in 1953. However, gross misbehavior and control problems had largely been resolved at the institution before the introduction of this program.

2. An intermediate step had taken place during the previous 2 years. Caseworkers during that period were assigned to cottage units to carry a caseload but without cottage-staff supervisory responsibilities.

3. Integration did not occur as smoothly and as effortlessly as the statement implies. Cottage groups were analyzed by the social-work supervisors and administrative staff. Some transfers and other staff changes were made. The basis on which new girls were assigned to cottages gradually changed with increased knowledge of the group composition and with more awareness of the abiilty of individual staff members to work constructively with particular girls. In this way we not only achieved better group balance but developed the cottage parent's ability to work with girls presenting a greater variety of problems. More staff time, education, and understanding became available to the girls. They received more opportunity for individual expression within the group. More help has been offered them individually and in groups for channeling drives positively.

4. Dr. Ohlin is probably referring to the experimental group incentive program in our vocational and academic schools. This is another project, requiring a paper in itself.

*Abraham G. Novick*
*Superintendent, New York State Training School for Girls, Hudson.*

## STRÖMGREN: *The importance of genes*

It was a pleasure to read this article by Erik Strömgren based on his address to the World Federation of Mental Health at Copenhagen. ("Genetics and Mental Health," CHILDREN, March–April 1958.) With increasing knowledge about the continuous interaction of genetic and nongenetic components of man's makeup in all periods of his life, psychiatric research workers seem at present to be less inclined than ever to minimize the effect of gene-specific metabolic processes in the organization of normal and abnormal behavior patterns, irrespective of the various levels of personality integration on which their interests are focussed.

It would seem essential, however, to point to a few formulations in Dr. Strömgren's report which may lend themselves to misinterpretation:

1. If mental-health work has been correctly defined as having "the goal to cure and to prevent mental disorders insofar as possible," it is clear that genetic studies, the aim of which is to search for basic causes in specific types of mental disorder, do not conflict with general psychiatric objectives.

It is a well-established fact that a gene exerts its action in a given area or environment, which in turn is largely the product of evolutionary development and genetically controlled interaction. If science, aided by the penetrating clues provided by genetic research, ever succeeds in unravelling this complex process and thereby helps in developing direct treatment procedures for so challenging a condition as schizophrenia, it would not be justified to say that "the genes . . . would lose their importance." Actually, the opposite would be true.

2. The twin-study method, if applied properly, provides a unique opportunity of investigating intrafamily variations with a minimum of uncontrolled variables, especially with respect to traits that present complex sampling problems and require comparisons in both cross-sectional and longitudinal directions. Dr. Strömgren characterizes the method as "weak" because "the environment may be more similar for the monovular twins than for the binovular . . . [It] will tend to treat identical twins in an identical way whereas the obvious differences between nonidentical twins will release different reactions from it.

This view would seem to disregard the fact that different reactions elicited from the mother in the early postnatal period will be caused by primary behavior differences in the infants rather than by the effect of hearsay reports on their zygosity (one-egg or two-egg). As to later personality development, psychodynamic concepts are also compatible with the premise that man being selective in respect to important aspects of his life can be thought of as "creating his own environment" (Alexander).

3. In his comments on homosexual behavior Dr. Strömgren states overt homosexuals can be divided into psychopathic and psychoneurotic groups.

The various mechanisms by which a postulated "gene-controlled disarrangement in the balance between male and female maturation tendencies" (Kallmann) may result in overt homosexual behavior have yet to be clarified. On the other hand, in line with Dr. Strömgren's own stated convictions, the presence of "obvious and convincing . . . psychological mechanism" expressed as a "serious life conflict" would neither rule out the operation of a genetic factor nor require the establishment of separate clinical groups. Instead, such research data and working hypotheses as have been provided by Kallmann's investigations should focus attention upon the entire developmental process in question and spur the organization of joint research projects combining the methods of demography, psychodynamics, physiological genetics, and chemistry.

As. Dr. Strömgren indicates, such interdisciplinary approaches are most likely eventually to provide adequate insight into normal and extreme variations in human behavior.

*John D. Rainer, M. D.*
*Associate Research Scientist, New York State Psychiatric Institute, New York.*

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## SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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STAFF TRAINING FOR PERSONNEL IN INSTITUTIONS FOR JUVENILE DELINQUENTS; report of a workshop. Elliot Studt and Bernard Russell. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Pub. No. 364. 1958. 56 pp. 25 cents.

Reports a 5-day series of meetings, planned to work out ways of using the skills and knowledge of professional and experienced but untrained workers in institutions for juvenile delinquents to the best advantage.

PROPOSALS FOR DRAFTING PRINCIPLES AND SUGGESTED LANGUAGE FOR LEGISLATION ON PUBLIC CHILD WELFARE AND YOUTH SERVICES. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1957. 130 pp. Single Copies available from the Children's Bureau without charge.

A guide to the development of State and local programs of child-welfare and youth services, issued for testing through discussion and use by individuals and groups interested in child welfare. Three alternative programs are included: a State-administered program for all children and youth; a partly State and partly locally administered program for all children and youth; and a State-administered program for delinquent children and youth.

HOMEMAKER SERVICE IN PUBLIC ASSISTANCE. Elizabeth Long. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance, PA Report No. 31. 1957. 29 pp. Single copies available from the Bureau of Public Assistance without charge.

A monograph on homemaker service in public assistance, with a case example of a local program.

THE SPECIAL MILK PROGRAM; its effect on consumption in St. Louis and Los Angeles schools. Department of Agriculture, Agricultural Marketing Service. Marketing Research Report No. 209. 45 pp. 25 cents.

Noting that the average daily consumption of milk per pupil in Los Angeles and St. Louis public high schools has more than doubled since introduction of the Federal-State Special Milk Program in 1955, this report analyzes the effects of factors in milk consumption such as price of milk, income of pupils' parents, education of adults in the school district, and number of times during the day that milk was available.

TEACHERS OF CHILDREN WHO ARE SOCIALLY AND EMOTIONALLY MALADJUSTED; a report based on findings from the study, "Qualification and Preparation of Teachers of Exceptional Children." Romaine P. Mackie, William C. Kvaraceus, and Harold M. Williams, in collaboration with Hazel F. Gabbard and Ernst H. Suerken. Department of Health, Education, and Welfare, Office of Education. Office of Education Bulletin 1957, No. 11. 92 pp. 45 cents.

A preliminary effort to define and describe the specialized competencies that a teacher needs in order to help socially and emotionally maladjusted children.

CHILDREN AND YOUTH; their health and welfare. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Pub. No. 363. 1958. 100 pp. 50 cents.

A chartbook presenting in graphic form facts about the health and welfare of children and youth in the United States, their economic and social status, and services they receive through public programs for maternal and child health, crippled children, and child welfare, along with information on juvenile delinquency.

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# children

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JULY • AUGUST 1958

# children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

**Children's Bureau Concerns**

**Value of Infant Tests**

**Beginning Service in ADC**

**Effects of Prenatal Nutrition**

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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FATHER AND SON, two refugees in a camp in Germany, are among the 40 million uprooted people in the world whose plight is to be the focus of the 1958 meeting of the World Federation for Mental Health in Vienna next month.

The picture is one of a number taken in refugee camps in Germany and Yugoslavia by Lisa Larsen for the Zellerbach Commission for European Refugees. The exhibit is currently on tour in several cities throughout this country.

## ◀ *the authors*

Nancy Bayley gained many of her observations on the use and value of child testing through a 26-year study of a group of normal children she conducted while serving as a research associate at the University of California's Institute of Child Welfare in Berkeley. During this period she also had interim research appointments at Stanford University and the University of Maryland. She has been in her present position since 1954.

In the January-February 1957 issue of CHILDREN Helen Tieszen (right) reported on the behavior of deprived Korean children. Rose Alvernaz (left) her colleague in the training program in which the behavior was observed and which they here describe is now in Korea under the auspices of the International Cooperation Administration as social-work consultant in the Korean Government's community development program. Miss Tieszen is teaching consultant at the Iowa Child Welfare Research Station, State University of Iowa.

Before going to the San Francisco regional office late in 1955, Helen Foster, then principal welfare-services specialist for the Bureau of Public Assistance, served on an interbureau committee of Public Assistance and Children's Bureau staff to consider services in the aid-to-dependent children program. She has since written a monograph on services in public assistance. (PA Report No. 30.) A native of Seattle, she was formerly supervisor of field services for the Washington State Department of Public Welfare.

Author of numerous articles on nutritional requirements during human growth, Genevieve Stearns has been teaching and doing nutritional research at the State University of Iowa since 1927, at first in the Department of Pediatrics and since 1954 in the Department of Orthopedics. With an associate, she has been a recipient of the Borden award of the American Home Economics Association and in 1950 was a member of a World Health Organization seminar team.

Rena Schulman has been on the staff of the Jewish Board of Guardians, a private children's service agency in New York, for the past 14 years, for 13 of them with the agency's institution, the Hawthorne Cedar Knolls School. She has been in her present position in the agency's child-guidance division since last November. In addition she works part-time with a family counseling agency, the Arthur Lehman Counseling Service. She is a graduate of the New York School of Social Work.

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# CURRENT CONCERNS OF THE CHILDREN'S BUREAU

KATHERINE BROWNELL OETTINGER

*Chief, Children's Bureau*

BY LAW AND TRADITION the Children's Bureau serves the children of the United States. The well and the sick, the whole and the handicapped, children in high-income and low-income families, children with and without parents, children who are nourished and loved in their families, children who are neglected, abused, or abandoned, children in majority and minority groups are included in the Children's Bureau's programs and objects of the Bureau's concern.

The legal base for the Bureau's services to these children is contained in two acts of Congress. Under the founding act of 1912 the Bureau is charged to investigate and report "upon all matters pertaining to the welfare of children and child life among all classes of our people."

Under title V of the Social Security Act, 1935, the Bureau, by delegation, is directed to assist the States, through technical and financial aid, in enhancing and protecting the health and welfare of their children, especially in rural areas.

Since the Social Security Act went into effect in 1936 the number of children under 18 years of age in our total population has risen from 41 million to an unpredicted 59 million in 1957. This boom is expected to continue.

The cooperation of the Federal Government and the States in these programs has resulted in a great acceleration in the progress toward promoting and protecting the well-being of children. From a total amount of a little over $8 million in 1936, the amount authorized by Congress for these grants rose to over $43 million in 1957.

At the same time these grants-in-aid have resulted in greatly stimulating the States' own efforts for children. For example, in 1940 State and local public welfare agencies spent an estimated $10 million for child-welfare services, $1,500,000 from Federal funds; in 1957, the States spent $46 million for these services, $7,300,000 from Federal funds.

Shifts in the population, which have resulted in a greatly accelerated trend toward urbanization in the past 23 years, may call for some modifications of the Social Security Act. Congress now has under consideration an administration bill which would remove the limitation on the provision of child-welfare services to rural areas.

Traditionally, the Children's Bureau has always held training and high standards of professional personnel as one way of advancing services for children and has encouraged the States to use Federal funds for the development of a high quality of professional personnel for the maternal and child health, crippled children's and child-welfare programs.

In the child-welfare program the majority of social workers serving rural areas under the public program have received their professional training through Federal child-welfare funds. The States, in turn, have concentrated on the training of supervisors, so that some 90 percent of the public child-welfare supervisors have had some professional social-work training.

Today the Children's Bureau is granting moneys to the States to strengthen the teaching to professional health workers of the content regarding physical and emotional growth and development. Three States have projects primarily designed to help five schools of social work provide more public-health content and to recruit social workers for the health field.

These projects are also used to offer institutes to social workers in public health on such subjects as growth and development of children, the meaning of

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**Based on a paper presented at the 1958 forum of National Conference on Social Welfare.**

hospitalization to children, mental-health implications of social work in public health, and consultation in public-health social work.

In its program against juvenile delinquency, the Bureau is encouraging the incorporation of material from the correctional field into the generic social-work curriculum. Two types of materials are being developed: material for use by graduate schools of social work to prepare social workers for work in corrections; material for inservice training of workers already in this field.

### *Strengthening Family Life*

Perhaps one of the most important gains for children today is the growing awareness of the need to protect and strengthen family life. Social workers long ago learned to trust the potentialities for growth in individual human beings. As the behavioral sciences have expanded concepts of family development—even families troubled by stresses and strains—social workers have been learning to have the same confidence in the ability of families to do their own growing with the right kind of help.

This faith in the capacities of families for growth and change is reflected in all of the services in the Children's Bureau programs. These are focusing more and more on the possibility of preserving whole families, of helping parents to provide, in their own homes, conditions which meet the growth needs of children.

For example, child-welfare workers today are giving more attention to serving children still in their own homes or in the homes of relatives. They are taking a sharper look at children in longtime foster care to see if their own homes can be strengthened, thereby permitting earlier return of the children. This is a process rather than program—and it is essentially interdisciplinary in character. All of the divisions of the Children's Bureau participate in it in a variety of ways.

Spurred on by the 1956 amendments to the Social Security Act, State welfare departments today are also giving more attention to providing services for children in families receiving aid to dependent children. The Children's Bureau continues to work closely with the Bureau of Public Assistance on finding ways of meeting these children's needs.

The failure to recognize and use homemaker and related services on a much broader scale in maintaining continuity in family life is puzzling. There is reason to believe that even if these services were expanded twentyfold, communities still would not be able to safeguard all families needing such services from temporary breakup in times of illness, family crisis, or death.

Therefore, the Children's Bureau, together with other Federal agencies and 24 national organizations, is sponsoring a conference to take place early in 1959, to explore ways in which communities can develop homemaker services.

In preparation for this conference, studies of homemaker and related services are now under way. Schedules from many local agencies which are providing such services are now being analyzed. When the findings are available a report will be made. Study groups already are being organized for fact-finding in connection with the conference. A directory of homemaker and related services will soon be available.

We at the Children's Bureau envisage this conference not as a means of perpetuating existing methods of providing homemaker and related services—no single image of how this service can or should operate is possible. We hope that we will be both creative and imaginative in finding numerous ways in which communities may expand these services. In doing so they may also be providing satisfying employment for some women past middle years.

Perhaps it may be possible to draw on the experience of other lands, where homemaker service is further developed.

### *Changes in Adoption*

The current emphasis on the importance of family life is also bringing out revolutionary changes in the field of adoption. More and more, social workers are appreciating that if children cannot remain in their own homes, live with relatives, or return to their own parents after a period of care or treatment in a foster-family home or a group-care facility, the alternative is a permanent home through adoption.

The social-work field is becoming more flexible in its attitudes toward adoption placement. For example, the insistence of a few years ago on the importance of a psychological examination and a period of observation for every infant as necessary preludes to adoptive placement is dying. Many children are being adopted at a much earlier age than social agencies used to allow.

New adoption programs, particularly in the public field, are being established and old ones expanded. This means more children are being placed by

**At the request of the President of the United States, the Secretary of Health, Education, and Welfare early in June invited the governors of the States and Territories to appoint State committees to participate in planning for the 1960 White House Conference on Children, referred to in Mrs. Oettinger's article. These committees will also serve as liaison groups between the States and the national advisory committee to be appointed by the President.**

**In his letter to the governors the Secretary suggested that the States might want to use this preconference planning "to see how far they have come in the last decade and where they should go in meeting the needs of children."**

agencies for adoption, including older children, children with physical or mental handicaps, and children belonging to minority groups.

Another significant development is the marked attention being given to the protection needed for these children, their natural parents, and their adoptive parents—protection found in good adoption laws, in social-agency standards and practices, and in a teamwork approach to adoption by various professions.

Recognizing that the social-work, legal, and medical professions have important roles to play in adoptions, the Children's Bureau has an exciting and rewarding project well under way. It grew out of a meeting held in June 1955 of persons representing national organizations in these fields. The result has been a series of meetings with selected groups of social workers, physicians, and attorneys. The Bureau is now developing pamphlets on the role of each profession in adoption.

The Children's Bureau is also embarked on a joint study, in conjunction with the Florida State Department of Welfare and the Russell Sage Foundation, on the outcome of independent adoptions and the factors associated with it. This is a rather new form of cooperative work, and we believe many important studies could be undertaken through collaboration with States and other organizations. We would particularly like to undertake a true control study comparing the results of independent and agency placements.

While gains have been made in this country in protecting all parties concerned in the adoption of children, a disturbing new development in adoptive placement has been taking place. This is the adoption by proxy of children from foreign countries by couples in the United States.

Within the space of slightly more than 6 months, over 400 children have been brought into this country by this means. The protections needed in adoption are bypassed when this is done. Little or no study is made of the prospective adoptive parents, very little is known about the child, no assurance can be given that parental rights have been safeguarded. Already we are hearing stories of individual tragedies which have resulted from these placements.

### *Preventing Disability*

Federally aided crippled children's services are making a major contribution to child health and welfare by care for children, especially in rural areas, in preventing disability. They make it possible for members of various professional disciplines to work as a unified team with the handicapped child, his parents, and his community in applying new knowledge from medical research in the treatment of crippling conditions and prevention of progressive disability.

An increasing number of children with physical handicaps other than orthopedic are now being included in State crippled children's programs. Initially, the emphasis was on the orthopedically handicapped. Now only about one-half of the 300,000 children receiving care have orthopedic handicaps.

These programs have benefited from a vast leap forward in meshing engineering, scientific, and medical-social findings to help the child amputee, starting with infancy. Other handicaps treated in the crippled children's program include heart disease, cerebral palsy, epilepsy, hearing impairment, and many kinds of congenital malformations. Such handicaps frequently affect children's physical, social, and emotional growth and development.

One of the most recent developments in the expression of the Bureau's concern for children has been its new emphasis on programs for mentally retarded children. In order to assist the State health departments in developing such community programs, the Congress, in appropriating $16 million for grants for maternal and child health in 1957 earmarked $1 million for special projects for mentally retarded children.

This has resulted in a rapid development of programs across the Nation. Thirty States are receiving special-project grants for services to the mentally retarded, and another State has plans in the process of approval. Despite the general difficulties that exist today with respect to recruitment of social workers, only 8 of the 47 positions for social workers for which recruitment has been under way in these projects are still unfilled.

These programs are particularly focused on preschool-age children who live at home or in a foster-family home rather than in an institution. Only 5 percent of the mentally retarded live in institutions. Most parents of retarded children want to keep their children at home as long as they are able. But in doing so they need help from the staff of community programs such as these.

State directors of clinical programs for the mentally retarded recently met together in Washington to review the brief experiences with these programs. Among the several major problems receiving particular consideration were: the difficulty in obtaining counseling or casework services in many communities; the small number of new patients who can be served in a clinic because of the time-consuming care required; and the difficulty in recruiting trained personnel.

Every now and then the Bureau receives a sober reminder of the importance of preserving a sound preventive program as the base for its activities.

In 1957, for the first time in over 20 years, infant mortality increased in the United States. In nearly two-thirds of the States higher risks in infancy prevailed for newborn babies as well as for those surviving the first month of life. The need for adequate prenatal care and child-health supervision is underscored by the fact that each year there are some 160,000 deaths which represent fetal losses, stillbirths, and deaths of newborn babies. The number of these deaths is exceeded only by deaths from cancer and cardiovascular diseases.

### *Emotional Growth*

If adults have difficulty in understanding the rapid changes taking place in society, how can children be expected not to be confused by them? At this time, perhaps more than at any other, persons in children's services must stand for a unified concept of the child as a growing, changing individual, influenced by his heredity, his family life, and his larger environment.

Therefore, it is encouraging to note that well-child centers and school health programs are giving increasing attention to the social and emotional problems of children. Each professional person in these settings is in a good position to recognize attitudes and behavior in young children which may suggest the need for referral to appropriate resources for examination and study.

Many parents are unprepared to cope with the various phases of adolescent development. The Children's Bureau has recognized this by extending its series of publications for parents to include a booklet on adolescence, which has become widely circulated.

The Bureau is also concerned with providing an awareness among the helping professions of the adolescent's need for support and guidance in resolving his conflict between dependence and self-assertion, and in helping communities become alert to the adolescent's need to find a useful niche in society.

Many obstetricians and pediatricians point out that adolescence is the most strategic time to prepare for satisfactory child bearing and child rearing. This means that health services, health education, and family and health counseling must be coordinated in more effective ways to capture the interests of adolescents in preparing to meet their future responsibilities.

And this future is not at all far ahead for the nearly 300,000 boys and girls in the United States under 18 years of age who are married, and an additional 15,000 under 18 who are widowed or divorced. In addition to these young married people are the 15 to 20 percent of college students who are married. The recent trend toward early marriages sharply points up the need for more frequent and intensive interdisciplinary consultation and communication on all aspects of education for family living, including parent education.

The alarm about juvenile delinquency has a real basis. The uniform crime reports, released April 23 of this year, tell us of a 9.8 percent increase in police arrests of children under 18 years in 1957, as compared with 1956.

The Children's Bureau, which over the years has developed what is now a national sample, finds little comfort that its own figures from the juvenile courts reinforce and sustain the evidence gathered by the Federal Bureau of Investigation.

Preliminary data from juvenile-court reports for 1957 show that there may be an increase of as much as 17 percent in the number of delinquent children referred to the courts since last year.

A relatively small core of social workers have been working to prevent delinquency for many years. Often they stand alone, upholding some of the basic concepts of the social-work profession while other social workers have taken the far too common attitude—let somebody else do *this* job.

Perhaps it is time that some of us came forward and answered some of the adverse criticism directed at the job our fellow professional workers are doing in juvenile delinquency.

For example, what is our reply to the statement which has been leveled by some newspaper columnists that the social workers' contribution to delinquency control is to buy the delinquent some soda pop and shower him with good intentions?

What is our answer to the accusation of mollycoddling when substantial members of the community advocate the brassknuckles approach to acts of vandalism in the community? How do we convey the intricacies of personality development, particularly when it is threatened by factors in the home, the school, or the community culture?

Social workers as yet do not have the full answers to these questions. With a few exceptions, they have only recently tried to do anything about antisocial gang behavior on an experimental basis.

The conference called by the Children's Bureau together with three national voluntary organizations last spring was the first national conference ever held on the problem of teen-age gangs. Work in this, as in other research explorations, is at a beginning. Social workers must continue to study, to search, to evaluate, and to work together with other disciplines in dealing with this enormous issue. Just as the public can become incensed about space rockets that fizzle on the launching pad, so the same public may become incensed about incomplete attempts to control gangs.

In this connection efforts must not be limited to cities with vast populations, since the latest statistics reveal that between 1956 and 1957 police arrests of children in cities with populations under 25,000 increased twice as much as in larger cities.

In 1956, $65 million was spent on institutions for delinquent children. At least 15 percent of the children admitted to State public training schools in a single year were being returned because of a new offense or violation of parole.

Social workers alone cannot supply the improvement that will reduce this figure. Other professions in correctional institutions need the training that stems from the body of knowledge which social workers have applied to human behavior. Recognizing this, the Ford Foundation, the Children's Bureau, and the Rutgers University School of Social Work, this year brought together administrators of public State training schools for an institute.

Nearly a million and a half children a year who are dealt with by policemen do not get into court. These law-enforcement officers are reaching out for a better understanding of the baffling problems with which they deal each day. The Children's Bureau is concerned with finding out what usable knowledge the social-work profession has to contribute to them.

### *Disadvantaged Groups*

Throughout its history, the Bureau has also looked ahead with concern to the special needs of groups of children disadvantaged either because of the time in which they lived, or because of factors in the physical or social environments of their communities. It continues to do so.

One of the most pervasive issues of our time centers in the fact that every town in this country is still faced one way or another with a problem of integrating the various elements of its population. I know of no town where experience even suggests that the integration of minorities has been completely achieved—whether they are Negroes, Puerto Ricans, Indians, Mexicans, Latin Americans, or French Canadians. In all of these instances, there is discrimination in varying degrees and the children of these peoples are affected by it and sometimes irreparably damaged by it.

It is no longer realistic to inquire whether mothers of young children should work. Many of them are working—in fact, some 7 million with children under 18. Of every 4 women in the labor force, one is a mother with one or more minor children. Moreover, 2.5 million of these mothers have children under 6.

The Children's Bureau is now engaged in a study that will tell something about the kind of care children receive while their mothers work; whether it is at home or elsewhere, whether someone is paid to look after them or they are entrusted to some friendly neighbor or relative; how many children are cared for by the paid mother substitute. The Bureau will also try to find out the extent of coverage of day-care facilities on a national basis, an extremely difficult task since each local situation seems to differ from any other. Without further investigation, however, we know that more services and facilities are needed for the daytime care of children whose mothers work and that greater efforts must be made in licensing and supervising such facilities.

Many mothers who are working and those who are deciding whether or not to work need counseling services to help them make their decision, to help them make satisfactory arrangements for the child if they decide to work, and often to help them find the kind of work that is right for them. Such services should rest on tested knowledge, not now available, about the effects of mothers' employment on their children.

In this country at least 9 million children under 18 live in families with a total annual money income of less than $2,000 a year. How are social and economic deprivations coupled in these families? What discrimination exists against these children and their families?

In today's swift new events, the economic effects of unemployment are obvious, but the effects on child life are somewhat less obvious and more insidious. Loss or decrease in family income means decreased standards of living, sometimes want for actual necessities of life, and increased insecurity and concern.

Loss of employment by the father may mean a changed pattern of family living. Eligibility for aid to dependent children may not exist if there is an employable father, and in many localities, adequate general assistance is not available. Unemployment may in some stress-ridden families be the last straw that precipitates family disintegration, thereby increasing demand for foster care.

The Bureau's concern with the unwed mother is traditional. Yet, even though social work has made some headway in promoting community understanding of the problems which lead to unwed motherhood, the fact that some State legislatures are still trying to pass punitive laws against children born out of wedlock proves that much remains to be done.

The unavoidable fact is that the unwed mother needs help—medical, social, legal service, rehabilitative consultation. And until she can get and use these services anywhere in the country, the black-market and gray-market placements of children for adoption will continue.

The number of children born out of wedlock is rapidly increasing. There were 193,500 such children born in the United States in 1956, as compared with an estimated 89,500 in 1940, a rise of 116 percent. Over half of this increase occurred since the end of World War II. Two out of five of these births were to teen-age girls.

What does an illegitimate pregnancy do to a girl's educational future? What does it do to her vocational plans? How many of these girls become lost because of public indifference and scorn?

The expansion of the Old-Age and Survivors Insurance program has revealed a need for more attention to the protection of child insurance beneficiaries who are away from their parents and relatives. The Children's Bureau and the Bureau of Old-Age and Survivors Insurance are planning to cooperate further in this effort, and have already made an exploratory study of a group of child insurance beneficiaries in foster care. This study gives clues that as we move ahead with social programs we must always stay alert to discover new situations in which society needs to protect the rights of children.

### *Assessing Future Needs*

Built into the rich tradition of the Children's Bureau is a natural method for the continuing assessment of how far the needs of children are being met in this country and in what directions further progress must be made.

This method has existed since 1909 when the first White House Conference on Children was called by President Theodore Roosevelt. That conference led to the establishment of the Children's Bureau and the Child Welfare League of America. Subsequent White House Conferences in each decade following have served as significant direction finders in the efforts toward improving the lot of children. The next White House Conference will be held in March 1960. Preliminary factfinding looking ahead to those days already has begun.

Judging from the many suggestions of a theme for the Conference which have come to the Bureau so far, the President's Advisory Committee for the Conference may select one focusing on the study of children and youth in a changing society.

The history of our civilization does not record a time when change was so rapid or so enmeshed in a growing complexity of scientific, physical, social, psychological, and cultural influences.

We in this country will make a worthy contribution to the history of civilization to the degree that we can make our programs for children responsive to this rapid change. The kind of vision we have in regard to children will largely determine the future of the world.

# VALUE AND LIMITATIONS OF INFANT TESTING

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IN RECENT YEARS the use of infant developmental tests has taken hold rapidly. Specialists who work with children, pediatricians, adoption agencies, and others have become accustomed to the use of a "D. Q." or a "developmental diagnosis" in appraising the status of infants. This is an excellent practice, so long as those who use and interpret the tests are aware of their values and their limitations. In general, tests are of great value in judging and diagnosing a child's current status, but they are of very little use in predicting what the child's I. Q. will be a few years later. However, persons who use the developmental tests have been slow to accept the fact that tests given in infancy do not predict later intelligence. A consideration of the nature both of the tests and of the way infants grow will help to clarify these points.

We may start by asking why intelligence tests for infants were devised and used in the first place. A brief survey of the history of such tests soon shows that tests for infants came into being as part of a larger endeavor to develop practical measurements of intellectual functioning in children and adults. About 50 years ago, Binet and Simon first devised practical, successful tests for evaluating children's mental ability.

Binet's original problem had been to identify children who did not have the mentality to profit from the regular school instruction. Although his scales included some items for infants as young as 3 months, his tests were oriented primarily toward school-age children. And it was to school-age children that they were applied for the most part in the early years of intelligence testing. These tests were a series of tasks and problems that presumably required intelligence to perform successfully. They were arranged in order of difficulty on the basis of the responses given by children of different ages. Thus a child could be given a "mental age" by comparing his scores on the tests with the average scores earned by children at each age, and finding the matching score and equivalent age.

Binet's tests were adapted widely in European countries and the United States. Among the best known revisions in this country are the Kuhlmann-Anderson and the Stanford-Binet. Many school children were tested, and the tests were found to have many applications. For example, they could be used to identify the average and the bright child, as well as the dull child.

In 1912, Stern and Kuhlmann suggested that a child's relative status could be indicated by means of a ratio between his mental age (the level of difficulty at which he performed) and his chronological age. The use of this ratio, the intelligence quotient, or I. Q., was included in Terman's 1916 revision of the Binet scale, and rapidly gained popularity.

This new tool, the intelligence test, stimulated many studies into the nature of intelligence. In the course of these researches elementary-school children were often retested after an interval of time. On these retests the I. Q.'s were found to be relatively unchanged, the changes in score falling for the most part within the range of expected error of measurement. That is, pretty consistently, on the basis of their test scores, bright children continued bright and retarded children remained retarded. These stabilities in the I. Q. were accepted as proof that the I. Q. is constant, and the short-term constancies were assumed to be representative of an inherently fixed lifetime characteristic. Intelligence was thought of as a capacity that each person is born with and that increases in a systematic fashion as he grows to maturity.

If this were true, then the earlier one could measure a child's intelligence, the simpler it would be to plan the course of his life for him. The next step, clearly, was to improve the tests for infants and standardize them adequately, so that reliable and valid I. Q.'s could be obtained in the first months or even weeks of life. By 1925, workers in this field were so thoroughly convinced of the constancy of the I. Q. that when the tests for infants were expanded and mental ages were developed for infants as young as one month the testers hardly bothered with retests to check for constancy.

## *Growth Studies*

At about the same time that standardized infant-intelligence or developmental tests became available, several careful studies of the growth of normal infants were started. In these studies, infants were measured and tested repeatedly as they grew older.[1] These studies soon indicated that development during infancy is irregular and for the most part unpredictable. Gradually, their findings were reported in the psychological literature. Bayley,[1] in 1933, showed that the children in the Berkeley Growth Study earned scores during the first year that were completely uncorrelated with their I. Q.'s at 3 years. Shirley soon reported similar inconstancy of growth rates in babies she followed for 2 years.[2] A series of studies at the Iowa Child Research Station,[3] and eventually many others, showed similar instability in the test scores of babies and young children.

Various explanations were offered for these unstable mental-growth rates. There is still a lack of consensus in the theories of the nature of early mental growth. Some experts hold that the growth of intelligence depends on adequate environmental stimulation.[4] Others claim that the emotional climate is an all-important factor in encouraging or inhibiting normal intellectual growth.[5, 6] Still others continue to maintain that growth in intelligence is basically stable and predictable when the existing tests are correctly used.[7] Others feel that tests can be designed that will prove to be adequate predictors.[1] Finally, there is the hypothesis that intellectual growth is inherently unstable, in part because of the changing nature of intellectual processes at different ages and their increasing complexity during development.[1]

These different hypotheses imply differing beliefs about the role of heredity in determining the course of mental growth. Those who hold that environmental impoverishment or enrichment or emotional climate are determining factors place little credence in the role of genetic factors. The unstable nature of early mental scores can, they believe, readily be attributed to variability in such environmental factors as these. Those who hold that mental growth in infancy is stable and that its course can be predicted, either by better use of current tests or by devising better tests, are of course convinced of the importance of genetic determiners. However, the genetic determination of intelligence need not require stable predictable growth of intelligence. The theory that the nature of the developing mental functions changes as a part of the maturational process is also a genetic theory.

Probably, the results of careful research will eventually show that this last hypothesis is basically true, but that all of the others play some part in determining any given child's intellectual growth. Let us consider some of the evidence from research for the role of these different factors, primarily from longitudinal studies—studies in which the same children have been tested repeatedly—and from studies that report parent-child similarities in intellectual capacity.

## *Berkeley Growth Study*

In the Berkeley Growth Study, the correlations between scores earned in the first 6 months actually correlate negatively with scores earned at 3 years and later. Similar small negative correlations are reported in other studies. Furthermore, the correlations between the infants' scores at about 6 months are negatively correlated with such measures of their parents' ability as education. As the children grow older, their test scores become more like those they earn at later ages, and also more like their parents' abilities.

If the gradual change to similarity with the parents were purely environmental, then we should have expected that the correlations in infancy would vary around zero, and not show, as they do, a trend toward a negative relationship. That is, it is hard to explain why the more able parents should create unfavorable environments for their babies. On the other hand, it is possible that there is a genetic tendency for slower maturing of the early simpler mental functions to go with eventually higher intelligence.

If we take a close look at the behaviors tested at different ages we see that they change in nature as they grow more difficult. In the early months of life we can observe and record only variations in sensory-motor coordinations and simple adaptive and adjustive responses. Among these adaptive responses we see gradually developing interpersonal communications in the form of gestures, vocalizations, and emotional attitudes. Out of these, language gradually develops; the increasing sensory discriminations become associated with a variety of experiences and take on meaning.

Gradually these meanings become attached to language and language takes on symbolic functions. The child begins to abstract and to generalize the meanings of his experiences, to think in words and other symbols rather than solely in the immediate and concrete. This is the kind of function we usually consider to be "intelligence" in school-age children and adults. In many ways it is very different from the sensory-motor functions of early infancy. These infantile behaviors are necessary developmental preliminaries to the more abstract intellectual functions of the older child. But precocity in the one evidently does not determine precocity in the other. Therefore, we need not expect that if abilities in both types of functions are inherited they are necessarily inherited in equal amounts.

One factor analysis of the correlations between mental-test scores at different ages of the Berkeley Growth Study children points to three discrete kinds of intellectual factors or functions, occurring at successive ages. Factor I, the sensory-motor, is dominant in the first year, with its highest loading around 8 months. Factor II is dominant the second and third years, with its highest loading around 30 months, and seems to be related to something like persistence or goal-directed behaviors. Factor III, which is not present at all during the first 8 months, becomes dominant at about 4 years, and after 6 years—when the I. Q.'s become stable—it appears to be the only one operating.

This factor III seems to be the "intelligence" which Binet was measuring, the kind of intellectual function that has been most studied. It is the general basic and stable mental capacity that is found in school-age children and is characterized as ability to learn and to carry on abstract thinking. Evidently it matures late, and is not present to be measured at first, and is not clearly measurable before 3 or 4 years of age.

### *Hereditary Determinants*

If we accept this hypothesis of the inherently changing nature of intelligence with growth, we must still consider the relative roles played by hereditary and environmental factors in the course of children's mental development. The data, when considered all together, seem to be best explained if we assume a solid core of hereditary determinants in intelligence. But its maturation is a dynamic process of interaction with those factors in the environment that are relevant to the given stage of maturity of the organism.

Let us consider some of the information we have from studies of parent-child relationships and other factors that seem to influence children's intelligence. To tease out the relative contributions of heredity and other determiners, we should, ideally, control or hold one constant and vary the others. This is not always possible, but much can be learned from studying parent-child similarities in children who grew up separated from their own parents. Another approach is the study of twins: monozygotic (one-egg) twins with identical inheritances are much more alike in intelligence than dizygotic (two-egg) twins whose inheritance is no more similar than ordinary brothers' and sisters'.

Several studies have been made of children who grew up in adoptive homes, never having lived with their natural mothers. One of the most pertinent to the questions we have been considering here is that made by Skodak and Skeels.[8] In this study the researchers had actual I. Q.'s for 100 mothers whose babies were placed in very early life in adoptive homes. These children were tested four times, the first test being given when they were about 2 years old and the last at an average age of 14 years.

Honzik[9] has shown the remarkable similarity in the pattern of increasing correlation between the children's and their own mother's intelligence for this group of adopted children and a group of children who grew up in their own homes. At 2 years the correlations in both instances were zero; at successive later testings the correlations became increasingly positive. At the 14-year testing the adoptive children's I. Q.'s showed a correlation with their true mothers' I. Q.'s of approximately .40. The other group of children showed somewhat higher correlations at this age with ratings of their mothers' intelligence (no test scores were available for their mothers). In both groups the correlations between children's I. Q.'s and their true mothers' education were very similar, varying from .34 to .38, while the adopted children's I. Q.'s remained unrelated to the educational level of their foster mothers.

### *Effects of Environment*

Now although the correlations are substantial and statistically significant between abilities of these 14-year olds and the mothers they never knew, they are not impressively high. There is much room for differences. Of course we should not expect perfect correlation of this kind of inherited factor. Even when measures of both parents are compared with their children's, the parent-child correlations in many physical measures are only around .50 to .60. Conrad and Jones[10] found parent-child correlations in intelligence to be .49 for a large group of families in which children were brought up in their own homes.

However, there are other differences between the Skodak and Skeels foster children and their true parents. The children's I. Q.'s were, as a group, much higher than their own parents', and even averaged well above 100, the average I. Q. In other words there is evidence that these children were benefited by growing up in good selected foster homes, in which their inherent capacities had every opportunity to develop.

Somewhat similar findings have been reported in some earlier studies, but these have less complete information for comparisons. Recently, Burt[11] has cited a series of such studies in England, all of which report parent-child similarities in intelligence, even though the children were not brought up by their own parents.

The classical study in this country on twins reared apart was made by Newman, Freeman, and Holzinger.[12] They found that identical twins who had grown up in different homes remained very much alike in intelligence, and definitely more alike than the nonidentical twin pairs. However, where there were extreme differences in the environment and in educational opportunity, there were also fairly large differences in I. Q.

The greatest difference was between a pair of young women. One, who had an I. Q. of 116, had grown up in a city and gone to college; the other, who had an I. Q. of 92, had lived all her life in a backward rural community and had only grade-school education. Here is one instance showing longtime effects of a generally impoverished, as compared with an enriched, environment. Although there is the substantial difference of 24 I. Q. points, the scores of both young women are within the range of normal and fairly close to average.

Educational and cultural opportunities are not the only environmental factors influencing the adequacy of mental functioning. Emotional disturbances, interest, and drives, can also play an important role. Several investigators have cited individual cases of infants who actually regressed in their developmental level in periods of profound emotional disturbance when separated from their mothers.[5, 6, 13] Bayley[4] reported correlations of about .30 between children's mental scores and ratings of emotional tone and attitudes on an "optimal" scale.

Many other studies report similar correlations. Recently, for example, Sontag and his associates[14] reported that emotional factors operated to depress or to accelerate children's mental growth rates. Bayley also found that in some children strong rivalries or other emotionally disturbing conditions could actually accelerate a child's mental growth.

Honzik, Macfarlane, and Allen[4] have studied the relation between growth curves of intelligence and emotional factors. They find that for many children stresses and strains in the home are very important in altering their test scores, but that other children maintain steady levels of ability in spite of great disturbances.

We have evidence, then, that the child's mental ability at any given time may be the result of a complex interaction of the mental function being measured and the impoverishment or enrichment of the environment in relation to that particular function and to the child's general happiness, drive, and direction of interests and preoccupations. There is still much to be learned about the relative roles of these factors and the signs by which we may become able to identify them.

### *Uses of Tests*

The foregoing discussion of the nature and determining factors in children's intelligence has led us far beyond the question of the usefulness of tests on infants. But it has laid a foundation on which we can now consider the question. It seems evident that the very nature of intelligence in children under 2 or 3 years of age is such that tests in these early ages will have little if any predictive value. There is probably more to be learned for predictive purposes from such factors as evidences of neurological and physical anomalies and from a knowledge of the abilities of the babies' own parents.

However, this does not mean that the tests should be discarded. They give valuable information in the diagnosis of a baby's current status. If an infant is below normal for his age according to the test scales, or if he has regressed in his performance, this is a sign that something is wrong. When test scores reveal significant deviations further observations should be made and appropriate inquiries instituted.

A child's characteristic responses to the standard testing procedures can reveal to the experienced examiner much about his normality or abnormality as compared with children the same age. Therefore the tests remain as important tools. Their use in developmental diagnosis when this term is understood to mean primarily the evaluation of the infant's current condition continues to be a very important and valid procedure.

Another basic and important use of these tests, for research purposes, should not be overlooked. The pursuit of knowledge about human development, the relation of development to learning and to the ways in which personality structures are formed, and the early determiners of mental health justify the continued interest in and improvement of infant tests.

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**One of the greatest deterrents to strengthening today's family is the confused notion that still exists concerning charity and social services. Basic social services are not charities; they are public utilities. With the advent of industrialization, including the development of the large commercial farm, the extended kinship-family had to be broken up. That family did have much of its social security system built in. For society to replace what it took away is as much or more in society's interest as it is in the individual family's.**

*Joseph H. Reid at the 1958 forum of the National Conference on Social Welfare.*

# TECHNICAL ASSISTANCE FOR CHILD WELFARE IN KOREA

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DOWN through the centuries men and women have left their own countries to work toward improvement of conditions among people of other lands in less fortunate circumstances. As time has advanced, a relatively small, but steadily increasing, portion of their efforts have focused on transmitting the kind of knowledge and skill that enable people to bring about their own improvements. Since World War II this emphasis, now known as "technical assistance," has received tremendous impetus through programs of international, governmental, and voluntary agencies.

Technicians, however, generally accustomed to applying their knowledge under very different conditions than they face on foreign assignments, have often had to learn from experience what in their own knowledge will be useful to the people they have come to help and what educational processes will be most likely to result in this being absorbed into the culture. Such was the experience of the authors of this article in planning and carrying out a technical-assistance project in child welfare in the Republic of Korea.

We had been sent to Korea independently in 1954 as child-welfare consultants by two voluntary organizations, the American-Korean Foundation and the Christian Children's Fund, Inc. With our agencies' permission we integrated our programs when we learned of the similarity of our purposes and the complementary nature of our professional backgrounds in social work and in preschool education and child development. Working together in the following 2 years we planned and carried out six leadership courses for institution administrators, six courses for child-welfare workers in children's institutions, and a course for the staffs of homes for babies.

During and before the Japanese occupation of Korea there had been little awareness of the need for organized social work. The extended family system provided a large measure of security for the individual. Because of a strong sense of family responsibility for even distant relatives, children without parents were usually provided for. Most of the few orphanages in existence had been started by foreign missionaries.

The partition of the country after its liberation from Japan in 1945 caused a major social upheaval characterized by the movement of masses of people from one part of the country to another. This upheaval was greatly aggravated by the ensuing Korean war, which left thousands of children homeless—separated from their families by death, the confusions of sudden flight, or the family's inability to feed them.

After the war, mass emergency needs in Korea were met by the United Nations Command by importing large quantities of relief goods. Distribution was carried out by the Korean Government, which, however, lacked appropriate structures, trained personnel, a tradition of public welfare, and administrative funds.

The Korean Civil Assistance Command (KCAC) was established to work with the Korean Government officials on the administration of health services and relief distribution. The United Nations Korean Rehabilitation Administration (UNKRA) recruited welfare officers and health personnel who were assigned to the regional KCAC teams working with Korean provincial government officials responsible for health and welfare locally.

Help to families was limited to rice rations, while children's institutions, hospitals, and refugee centers received fuller aid. This in a sense spurred a breakdown of the family system, for needy people flocked to the institutions with relatives young and old for whom they could get help no other way. Institutions suddenly multiplied all over the land without any overall planning.

Many foreign voluntary agencies also poured emergency material aid into Korea. As in the case of Government aid, their relief supplies were mainly distributed through institutions.

Many of the children's institutions were begun as a response to an emergency by good-hearted Korean people who opened their homes to orphans and stranded children during the war. Left with the children on their hands and encouraged to keep them by the aid available, many of these people had no knowledge of the various problems involved in rearing large groups of children and of the needs of those who, having no families, are without community status.

In the Korean culture, where the individual gains status from his position in the family and the position of the family in the community, persons without family are often held in low esteem. Thus, an American director of a school for orphan boys found the villagers coming to him with the question: "Why do you help the orphans? They aren't good boys, otherwise they wouldn't be orphans. Why don't you help the children of poor families?"

Aware of the need for trained personnel to meet children's needs more adequately, Korean welfare officials, UNKRA, and KCAC asked the American-Korean Foundation when it was organized in 1953 to recruit professional staff who would help the Koreans develop child-care and child-welfare services and train personnel for those services. The authority of the foreign agencies to develop a training program in cooperation with Government and voluntary agencies in Korea was derived from the basic agreement between the Korean Government and the United Nations Command. The American-Korean Foundation recruited and paid the salaries of the consultants who were "attached" to the Korean Civil Assistance Command, working with and through that agency. Similarly the Mennonite Central Committee recruited staff which worked under the Christian Children's Fund. The responsibility for the technical-assistance aspects of the program was later assumed by the International Cooperation Administration.

### *Educational Methods*

As child-welfare consultants in this program we were conscious of having a broader responsibility than merely imparting information. Our goal was to achieve change in the behavior and attitudes of the trainees and to foster their ability to use a creative approach to the problems before them.

The first step, we found, had to be to stimulate them to take an interest in each child as an individual having emotional, social, and spiritual needs. Only as this goal was achieved would the trainees be ready to modify constructively their ways of dealing with children. Then as they developed a deeper understanding of the range of children's needs they would be better able to find ways of meeting these in harmony with their nation's cultural patterns.

We also realized that we had to keep our program in gear with the fact that many of our trainees were very poorly paid institutional personnel who had selected their occupation on the basis of having no other means of livelihood. At the same time the program had to serve as a foundation for the further development of those persons who were capable and willing to become well-trained child-care workers.

We agreed that the plan of instruction most likely to have a lasting effect would consist of classes for institutional personnel to stimulate their interest in children as individuals and to impart some understanding of psychological and sociological concepts

While the child-care consultants in Korea used interpreters in working with adults, they found language differences to be hardly any barrier in communicating with children, as Miss Alvernaz here demonstrates on the steps of a Korean orphanage.

These young residents of a Korean institution are being shown how to make puppets and other toys by child-care trainees.

of child development and behavior. Follow-up advice and suggestions would be given as the trainees continued on their jobs. In practice, this evolved into a threefold program with 1-week leadership courses for directors of institutions, 3-week courses for child-care workers in immediate day-to-day contacts with children, and followup work to assist trainees in their attempts to apply their new understanding.

The courses were open only to persons already working in institutions. In an effort to keep the classes small enough for free discussions, each course for childcare workers was limited to 30 trainees and each for superintendents to 40, in an effort to keep the classes small enough for free discussion. Conducted under the auspices of the provincial League of Social Workers, a semiofficial organization of institution directors, they were carried out in the provinces where the institutions were located.

Local doctors, nurses, and educators were called upon frequently to lecture and in doing so not only contributed to the trainees' knowledge but learned something themselves about institutions, an important move toward the creation of community interest and understanding. Since the locale of the classes was always an institution, the trainees had an excellent opportunity to observe the meaning of the concepts they were learning in actual child behavior.

We tried to keep the program really a project of the League of Social Workers by giving as much responsibility as possible to its officials. As they became familiar with content as well as objectives of the courses, they helped to formulate the plans for the courses in the various communities and assumed responsibility for specific lectures in the development and presentation of play materials. At first, this required a great deal of interpretation of the purposes and methods of the plan as they did not understand what was expected of them. We defined our role as giving guidance and assistance in planning the courses and providing some of the content.

Since neither of us was at all adept at speaking Korean, we had to work through interpreters. They became invaluable assistants, each of them contributing far more than a literal translation of our words and eventually assuming major responsibilities for the courses.

In addition to lectures and discussions, the courses included workshops involving direct observation of children. These methods were completely new to the trainees. They were accustomed to teachers who outlined each lecture for them to write in their notebooks. Being expected to think for themselves in class was a novel experience for them, and at first they thought they were learning nothing. We found that asking for written questions was an effective way of starting discussions for, although the trainees at first were apt to be too shy to talk in class, they were willing to put questions on paper. In each instance, as the course progressed, most of the trainees learned to participate actively in all the class procedures.

As part of our followup work we visited a number of institutions to observe practice and assist in working out specific problems. While this was a rather awkward, time-consuming method of instruction in relation to the total program, it kept us in direct touch with needs and provided us with a matrix for developing instructional materials. However, these values might be retained by selecting one or two institutions for intensive instruction. Indiscriminate visiting includes a danger that followup work will become concentrated in poorly managed orphanages with blatant needs, whereas the better institutions with staff members who are open-minded and ready to learn remain neglected.

### *The Program's Effectiveness*

In view of the great needs, what we actually accomplished sometimes seems dismally little. Every course included trainees who were unable to assimilate new ideas, while some of the best students did not long remain in institutional work but left to get married or for other reasons. Sometimes, the native leadership did not comprehend the purpose of the course. However, the number of successes was large enough to lead us to believe that better care of children actually resulted from the training courses and that some of the participants are now better equipped to handle new problems as they come up.

Following one course, a group of 15 child-care workers formed the Bo A Yun Gu Whai (Housemothers' Child Study Monthly Meeting). As they met from month to month, their growing awareness of the possibilities in their role as housemothers became apparent. Some of those who had seemed passive and disinterested in the classes came alive with enthusiasm in these monthly meetings. They began giving more attention to children whom they had previously regarded as rather undesirable because of their behavior and they expressed amazement at the results. Because they knew the need for more written material in the field of child care, from time to time they issued a little bulletin for distribution among the orphanages. Their discussions centered on actual cases, relating general concepts to real experiences with children, such as bedwetting, stubbornness, and frequent crying.

Other groups of trainees also continued to meet together regularly after their course had ended. One group composed of child-care workers from institutions around Seoul prepared an agenda and summary of each meeting which were mimeographed and distributed to a much larger group by the local League of Social Workers.

We found directing attention to actual experiences to be a most effective teaching device. It helped to avoid the expression of platitudes without any realization of their meaning, though this did occur frequently among the trainees. For instance, one superintendent who spoke at great length about the necessity for treating the orphans as he would members of his own family turned out to be using a spy system to learn who the "bad" children were. To counterbalance such excessive verbalization of undigested theory, trainees known to be putting theories into practice were encouraged to participate in the discussions. Many persons who expounded theory were genuinely concerned with improving child care and planning, and merely needed assistance in translating their thoughts to down-to-earth practice.

By drawing on the trainees' actual experiences as illustrations, we tried to build the educational program on already existing positive elements. This helped us to avoid teaching content that would be valuable in the United States but would have little meaning in the Korean culture. Though we found that many problems of child care in Korea were similar to those encountered in the United States and believed the basic elements of child development to be the same in both places, some specific ways of nurturing children and meeting child-care problems were bound to be quite different.

The observation groups in courses for child-care workers provided the trainees with concrete examples of what they had been discussing. Thus, they could actually see before them the effectiveness of adult interest on the behavior of children. Each trainee took notes on a specific child's behavior as it occurred and then wrote a paper on the basis of his observations. This helped him to become aware of significant aspects of the child's reactions to other children, adults, and materials. Such awareness, we hoped, would increase the trainee's understanding of why planning for children must include consideration of their requirements for growth and development and for adjustment to society.[1]

Through the monthly meetings with child-care workers who had taken the courses we found evidence that at least some trainees continued to grow in understanding and to improve their skills long after the course ended. We also learned of their difficulties in applying what they learned in their own institutions. They found, for instance, that solving a behavior problem in one child may create problems in other children and thus were faced with the necessity of keeping the entire group in mind while planning for individuals. Some institutions started regular staff meetings to plan for children as individuals and as a group. On the whole, we found it effective to precede the courses for child-care workers with leadership courses. Directors feel more secure in sending workers for training when they have some notion of what they are going to learn and some confidence in the instructors. Moreover, when the child-care workers return to their institutions, they are more likely to do effective work if their directors understand what they are trying to do.

We were faced with this realization after a small, experimental course which specialized in the care of infants. Although a few superintendents had had courses, no leadership course had been especially designed to precede this particular course for child-care workers. As a result, several of the workers were unable to accomplish much when they returned to their institutions because the superintendents did not understand their new notions.

We found some directors to be so involved with the struggle for existence that they had difficulty in centering their attention on children's needs. Nevertheless, we felt that even these managed to absorb at least a faint idea of some child-welfare concepts through the courses.

Other directors showed definite interest in child care and discussed children in sound, sensible terms. A live interest was particularly evident at the leadership course given at Cholla Puk Do. In addition to their genuine concern for the welfare of children, the directors in this area possessed a history of cooperation in solving mutual problems. Obviously feeling secure with one another they discussed their problems freely. A unit of the American Friends Service Committee in Kunsan which had worked with them had undoubtedly helped to build up this feeling of unity.

### *Cultural Considerations*

In any culture, scientific and technical knowledge sometimes supplements, sometimes undermines traditional patterns. In training courses, traditional ways can be reinforced or they can be changed. Nutrition experts, for instance, have found that the prevalent Korean pickle, kimchi, contains some necessary vitamins. The traditional Korean practice of bottle-feeding babies with rice water, however, provides little nourishment and needs to be supplanted by western methods of formula preparation.

The sheer number of children in institutions and the scarcity of resources make it impossible for the child-care workers to apply some of the most important of the culture's child-care patterns. For example, the traditional way for an infant or young child to find security in the Korean family is to be carried on his mother's back most of the day, a practice which assures him of continuous comfort and warmth. When one person cares for as many as 10 or more children of the same age, this becomes impossible. The traditional pattern must then be replaced with other ways of providing warmth as well as confident adult-child relationships and these new patterns must be in harmony with other aspects of the culture. In many institutions, however, the staff lacks the interest, imagination, or academic background for crystallizing such problems and finding solutions.

Coordinating instruction with community resources by calling in local professionals to lecture proved to be an effective way of keeping the courses close to the culture and at the same time demonstrating the values of working with the community. In some areas the foreign agencies themselves were exhibiting a need for coordination. In Pusan, for instance, one of the foreign doctors was concerned about the confusion resulting from the number of persons independently attempting to improve the preparation of milk in babies' homes, each in a slightly different way.

As child-welfare consultants we participated in the Child Welfare Committee, a group of foreign and Korean professional workers who advise the ROK Ministry of Health and Social Affairs on various child-welfare problems as requested. The interchange of information and ideas provided a means of gaining a more complete picture of child welfare in Korea and of being helpful to others.

In cooperation with the Korea Association of Voluntary Agencies we planned a series of meetings for the staff of the member agencies, to discuss basic social-work concepts in their relation to welfare activities in Korea, taking into consideration social, economic, and cultural factors.

All of these groups, from housemothers' meetings to Child Welfare Committee, revealed the need for defining technical concepts in relation to the cultural environment. Even simple terms such as "adoption," "casework," "recreation," or "vocational training" carry an entirely different set of associations in Korea than in the United States. To be effective, technical assistants have to be aware of and respect these differences in associations. One can, of course, work towards ultimate reorientation in instances where this seems desirable, but the process is slow and must proceed from a sound basis.

For instance, we soon found that it was not sufficient to say that planning for play opportunities for institutionalized children is necessary. Such a statement only met with the response that since these were poor children they needed to learn to work rather than to play. However, when the subject of play was related to the development of self-expression, skills, and the acquisition of knowledge about the environment, the trainees responded more positively to the idea of planning play activities for the children.

Generally speaking, young women between the ages of 20 and 30 seemed to be more open to instruction. In a culture which does not ordinarily value the opinion of women, however, an older person commands greater respect and so can accomplish more.

We spent considerable effort trying to round up suitable materials for instruction. The American-Korean Foundation mimeographed a number of pamphlets on child health, nutrition, and welfare for use in the courses. The Health Division of the Office of the Economic Coordinator, ICA, provided several excellent sets of charts and posters. UNICEF furnished materials on the preparation of powdered milk. The United States Information Service was the source of some fine films on the subjects of child development and sanitation. We also found children's literature and music but the supply was meager. Many of the play materials for the child-care observation groups had to be especially made.

### *Continued Needs*

The need for basic education in child care among Korean institutional personnel continues. Not all the leadership courses have been followed by courses for child-care workers. A constant turnover in personnel in institutions makes it necessary for those which have sent staff members to courses to keep repeating the process. Several provinces have had no courses at all.

Persons who have had the beginning courses show eagerness for more training involving supervised participation in work with children. Some of them are ready to learn how to make case studies and keep records.

Among child-care workers generally a greater understanding of group processes and constructive activities for children would be useful. They also need assistance in planning vocational training for young people. The whole area of baby care has hardly been touched.

Although the great increase in homeless children during the war was regarded for a while to be a temporary phenomenon, the number of abandoned children is continuing to swell the population of children's institutions. Until more families can care for their own children, Korea will have to be concerned with large-scale institutional care and the development of other child-welfare services. Realizing this, Koreans are beginning to be interested in ways of keeping families together.

The organization of the education program will likely take a different form in the future. The American-Korean Foundation is pulling out of this type of program, and the Office of the Economic Coordinator is changing its focus to the training of community workers—a much-needed emphasis which will bring the institutions the benefits of additional community resources.

**A Korean child-care trainee prepares food from foreign relief supplies furnished to institutions through the Korean Government. After the Korean war the availability of food in institutions attracted many persons to institutional jobs.**

Currently, the ROK Ministry of Health and Social Affairs is setting up a national training center for orphange workers. Through this the institutions will be able to seek the advice of competent people of their own culture who can do much that is not seemly or proper for foreigners to do. The Ministry is interested in having the consultation of qualified foreign technicians on this project.

Korean personnel are becoming more readily available to develop welfare and welfare-education programs. The assistants in the courses we have described worked in nutrition, health, child development, reasearch, and the development of teaching materials. Having developed real skill, they will be able to make an outstanding contribution in any future program. As Korean personnel are trained to take over one type of training course, foreign personnel will be free to develop courses needed in other phases of the program.

Since Korean universities are setting up schools of social work, native professional social workers will be available in the future. There will, however, be continued need for foreign technical assistance and support until the time when sufficient Korean leadership is trained.

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# WHERE HELPFULNESS BEGINS IN AID TO DEPENDENT CHILDREN

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THE function of social workers is to be helpful to people. We see the varying needs people bring to us and we know flexibility and imagination are required to help them. We also know that psychological hazards can endanger our ability to be helpful when we must meet our client in the highly structured setting of the public-assistance eligibility process. This is a setting with predetermined limits—eligibility requirements—over which neither we nor the client have any control. Sometimes these limits are narrow and rigid and often we must say "No" to our client even though the burdens that he carries may be very great.

It is not surprising therefore that for a period of time the eligibility process fell into a sort of professional disrepute, often being regarded as something required by law to be got through as soon as possible so that either the client alone or the worker and client together could go on about more dynamic business. This attitude found expression in various ways—in arguments that social-work skills were not required to determine a person's need for public assistance or that public assistance was a mass program involving neither the time nor the necessity to do more than to assure that only eligible people received public funds, and in the sequence of administrative plans, providing first for the determination of eligibility and subsequently for services as time and skills permitted.

In recent years public-welfare agencies have been trying to find out how the public-assistance program can provide more constructive help to all the people it serves. This has resulted in more precise and thoughtful administration in many areas. But particularly it has brought new awareness of the significance of the eligibility process in the agency's relationship with the client. The old idea that the discussion of eligibility factors is a sort of self-contained routine process with an identity of its own has given way to a view of the agency's relationship with the client as a continuum, with the helping role beginning at the point of initial contact. While this is not a new casework concept, the understanding of its applicability in public assistance came only as a result of increased experience in public-welfare practice.

From experience as casework practitioners, we learned that the essential value of money to all people is to buy life and that when we talk to people about how much money they have and how much they are eligible to receive we are touching their lives profoundly. We learned that measuring the person against legal requirements leaves him neither unmoved nor unmoving. We learned that what we do and say in all our contacts with the person, especially the initial ones, can either contribute to his capacity for independent functioning or detract from it.

## *Freeing the Client*

Of very considerable value in public assistance is what we have learned about how much help we can give a client in only a few contacts concerning simple matters. We often found that help in relation to a small, practical problem could provide encouragement to an individual and free his energies enough to enable him to move ahead on his own to deal with other problems without our direct help.

What then, have social workers learned to do in determining eligibility which not only serves the agency's legal requirements but which supports and strengthens the client's capacities to function responsibly? Particularly, what are social workers doing in this process which helps people be better parents and which contributes to family solidarity?

The balance of this article will discuss some of these helping steps, using illustrations from an actual public-assistance case record.[1] This is not a "special" case nor was it carried by a "special" worker as a part of a consciously organized agency activity. Recording was not detailed or lengthy.

The family involved had been broken by the death of the father, who was killed in an automobile accident while drunk, leaving a widow, two children of school age and a daughter, Carol, age 19. Carol had left school at 15 but remained at home with no particular plans for the future. An older son, Edward, then in the Marines, had also been home dependent upon his family for some period of time after leaving school. Family income even before the father's death had always been marginal and standards of management never high. The mother was regarded by relatives as an ineffectual person who had been completely dominated by her husband.

The worker's activities all had bearing on the eligibility of the family for assistance and on their financial need, viewed even in its narrowest sense. In a wider sense, her activities focused on helping the family develop personal and financial resources needed for both immediate use and for future family well-being. The mother was helped to accumulate all the information needed to establish ages of children, the details of her husband's estate, eligibility for social-security benefits, and other significant data. Eye and dental care were authorized for the mother. Steps were taken to help Carol begin planning toward the achievement of independence. Considerable effort went into encouraging Edward to remain in the Marines and eventually to make an allotment to the family. In this process, the social worker made use of the advice and encouragement of relatives close to the mother, of the recruiting office who knew Edward, and of the Red Cross in working with his chaplain and with his commanding officer.

Basic to all the social worker's activity were the diagnostic clues the worker secured of the family in an operational sense. These enabled her to gear her activity to the immediate practical help the family needed. The worker secured past history, not as such, but bit by bit as the information came out naturally in the discussion of eligibility factors. As she talked and worked with the family in securing this information, the worker observed how spontaneously the mother and children related to each other, how they reacted to their immediate stresses, what seemed to be troubling them at the time, and how her own observations compared with opinions expressed by others outside the primary family unit.

For example:

> Mrs. D. seemed to have recovered very well from the shock of her husband's death and was able to take part in the interview in a much more competent manner than worker had been led to believe she would be from conversation of other members of the family. She stated she had only attended school through the fourth grade and thus found it difficult at times to read and write but went on to remark that part of her difficulty was because she had trouble with her eyes. . . . but they had never been able to afford glasses. Worker noted, however, that Mrs. D. frequently looked to her children, Tommy and Carol, for help in finding information and in answering questions.
>
> Carol (age 19) is a small, rather immature girl who looks and acts much younger than her years. Her mother seemed to depend upon her for help in such matters as finding birth certificates and figuring out the family budget. She said she needs Carol at home and did not seem to feel that Carol was obliged in any way to leave or provide for her own needs. Carol herself showed a little interest in working but seemed to feel that she was not qualified for any work that would be available locally. Worker promised to keep Carol in mind should any employment suited to her come up in this vicinity and to discuss this with the D.'s later.

In her attempt to understand the family in an operational sense the worker saw both inner and outer problems which were handicapping effective functioning. For example, Mrs. D. seemed to be a dependent and somewhat inadequate person, who was perhaps bringing up her children in a similar pattern of dependency. However, the worker did not try to approach personality defects directly or to delve into the developmental experiences which produced them. Rather, throughout her contacts with the family, she focused her efforts on helping the members handle their disabling attitudes in relation to current and practical situations facing the family and on relieving environmental stresses. In this approach certain factors can be identified which made the eligibility process a dynamic experience for both the client and the agency.

## *Widening Horizons*

One helpful occurrence which can take place in the discussion of eligibility factors is the widening of the client's horizon so that he can see that even though he may be in serious trouble some choices are still left open to him, that he can still move on his own, and that he still has personal resources to use.

Because of the importance of financial independence in our culture and all of the status significance attached to it, application for public assistance is often unconsciously regarded by both staff and client as a last resort. When financial need is accompanied by the personally devastating experience of family breakdown the individual applicant often becomes immobilized, going around and around in the same pressing pattern of trouble from which he sees no escape.

Under some circumstances an application for assistance can represent to an applicant the relinquishment to the welfare department of any further responsibility in a personally impossible situation. Therefore, it is important for the discussion of eligibility factors to be in terms of their meaning to this particular person and not solely in terms of agency requirements. The areas in which information is needed to establish eligibility in the aid-to-dependent-children program are those areas in which any mother without a husband needs to organize her thinking and come to conclusions if she is to move ahead responsibly.

For example, the worker reviews financial resources, not just to measure financial need but to help the mother start thinking about what immediate steps she needs to take about such things as converting or conserving life insurance, consolidating debts, or securing legal entitlements. For example:

**Worker emphasized to Mrs. D. the importance of getting all records in order, as they would be needed in case Mr. D. had sufficient coverage under social security to be eligible for social-security benefits.**

Seldom is there a mother who when asked to recall the birth date of her child does not also think of him, at least fleetingly, in such terms as: Is he well? Is he happy? Is he getting along in school? What help does he need from me? Similarly, if the focus is on the eligibility factor of the father's absence, the deserted mother must also be thinking about such things as: Why did this happen? Will he return? Do I want him to return? Do the children miss him? How could I locate him? What responsibilities does he have for me and the children? Discussion of such eligibility factors with the mother in relation to their meaning to her and to the children can provide the impetus for her to begin to turn at least some of her fleeting thoughts into organized action.

For example:

**. . . the possibility of Carol making some plans for the future were discussed with Carol and Mrs. D. Carol stated she had quit school at the age of 15 as she did not have proper clothes to wear and she felt that the other children looked down on her. . . . Worker inquired whether she was interested in attending school if she could go as an ungraded student and perhaps learn some skills that would help her in finding work. Carol showed some interest in this proposal and it was agreed that an effort would be made to have her admitted to the Hicksville School.**

In many instances the choices open to the applicant as revealed by the discussion of eligibility factors may seem very meager when measured against the magnitude of the family's problems. The psychological significance to the parent can be great, however, if out of the eligibility discussion she begins to see that there *are* choices open to her and possibilities for positive action.

### *Experiencing Accomplishment*

Closely related to this opportunity for widening the client's horizons is the opportunity the eligibility process can provide the client for experiencing accomplishment through participation with the worker in establishing the facts about his situation. Many parents applying for ADC at the present time are deeply troubled people who, for a variety of reasons, have had little experience in successful accomplishment or who have lost confidence in their ability to act in their own behalf.

The mother who is encouraged to collect the data necessary to establish her eligibility and to decide what she is going to do about the practical problems she faces today, tomorrow, and next week is beginning to experience how to go about something in an orderly way. Successful accomplishment in even small but tangible activities generates further accomplishment by providing the impetus for the mother to move ahead on her own in relation to other problems.

The caseworker's relationship with Mrs. D. was one which consistently provided her with an opportunity to participate in planning and with support in carrying her responsibilities. The following selections from a 2-month period in the record are in chronological order and so reveal Mrs. D.'s increasing capacity to take action on her own.

**Mrs. D. was again urged to write to the social-security office to make application for social security benefits for herself and children. . . . Mrs. D. stated she did not know how to write to the social-security office and asked whether worker would help her with it. A worker wrote to the social-security office but suggested to Mrs. D. that she write also.**

**It was mutually agreed that the department would contact Edward's chaplain and his commanding officer about this matter (Edward's threat to go AWOL and return home) . . . . at suggestion of the worker, Mrs. D. with the help of her daughter wrote a letter to the chaplain. As she did not know the ad-**

dress, worker took this letter with the understanding that it was to be sent to the chaplain together with a letter from the department.

Worker suggested that Mrs. D. write to Irvington or go there to get proof of her marriage and proof of the children's birth dates. Mrs. D. stated that she had succeeded in finding all of the children's birth certificates but that she did not have her marriage license. She was informed of the proper procedure to follow in sending for this. Worker also discussed this with Louise S. (sister-in-law) so that she too would know what was required as she will no doubt be called upon to help Mrs. D. Worker also told Mrs. D. of the date when the social-security representative would come to Huntington so that she could go there to see him. . . . Worker explained to Mrs. D. that she would also receive an $80 death benefit. Mrs. D. inquired whether she was required to pay for her husband's funeral and was informed the matter was up to her. Worker explained that this funeral bill had not been paid as the agency thought perhaps Mrs. D. might like to take care of this matter herself and that this would be her own decision. Mrs. D. said she would think this over and later as the worker was preparing to leave the village after another call, Mrs. D. ran up to the car and stated she had decided she wanted to use this money to pay her husband's funeral costs.

### *Cultural Expectations*

The activity and relationship occurring in the eligibility process may also be used to reemphasize cultural values which may have become overlooked in a troubled life and thus to strengthen the parental role and the mother's confidence in herself.

In a period of crisis even the best parents must devote the major part of their energies to the demands of the crisis and so have less to give to their children until the crisis has passed. At such times responsible parents do not regard it as important if for a day or two the children do not go to school or if they eat makeshift meals. These parents will pick up their parental role again when the crisis has eased.

If, however, as is true of many mothers receiving ADC grants, one's entire life is made up of crises—of fending off irate creditors, of having no regular income to count on, of frequent moves, of trouble with the law, of uncertainty about what other members of the family are going to do next—the normal requirements of the parental role become obscured in the pressing, private world of day-to-day expediency. Under such circumstances a person's social expectations become very meager and the need for personal gratification very immediate. It comes to be an expected part of life that one's children have trouble in school and are otherwise unsuccessful, that they will have untreated illnesses, and that the exercise of parental discipline is at the risk of further loss of the love which already seems in short supply.

To the client the welfare department represents the community, sometimes unfortunately in a threatening, authoritative sense. In a casework relationship however, beginning during the discussion of eligibility factors, the worker can help the mother regain some perspective on the cultural expectations of the parental role merely through the matters to which she draws the mother's attention, such as the health of the children, how they get along in school, what responsibilities older children are assuming, and the like. The social expectations of the mother may be enlarged somewhat also by the fact that the worker, a responsible member of the community, is saying in effect by her concern with various aspects of family functioning, "Your particular situation is not inevitable—you are a part of the community too."

As the relationship progresses, the social worker can support the mother's self-esteem by showing appreciation of her own needs—that the health of parents is important too, for example—and that it is all right for mothers to have reasonable expectations for their children. We see this sort of simple activity going on in the D. case. The worker urges that Tommy not stay out of school longer because of his father's death. She discusses the mother's need for glasses and dental care. She discusses future plans for Carol (because most teen-age girls these days do not just leave school at 15, as Carol did, and stay at home).

### *Encouraging Responsibility*

The kind of encouragement the worker can give both to parents and children in assuming more responsible but sometimes frightening and unfamiliar roles is illustrated by some excerpts from the D. case record concerning Edward's desire to get a hardship discharge from the Marines. Thus we see both Edward's and his mother's attitudes changing to permit them to carry more responsible roles than hitherto.

At the first contact:

Mrs. D. said that Edward did not like being in the Marines very well but she agreed when worker remarked that perhaps he would like it better after he had finished his basic training. Worker suggested that it might be possible for Edward to make an allotment for his mother but Mrs. D. objected to this idea stating that any money which he earned should be his. Worker suggested that perhaps Edward wanted to help her and that it would be better for him to send her money than to spend it foolishly. Mrs. D. agreed rather reluctantly. Because of information given by Mrs. D.'s relatives (on Edward's past irresponsible behavior) worker wrote a letter to the social-service director of the Red Cross, informing him of Edward's inten-

> tions (to get a hardship discharge) and advising him of the department's feeling that it would be much better for Edward to remain in the service and possibly to make plans for an allotment later.

A month later:

> Mrs. D. stated that she was very glad the worker had called as Edward had written a letter to her . . . asking for help in getting a hardship discharge in order that he might come home and help the family. Mrs. D. was very disturbed over this. She said that she felt it was best for Edward and for her and the children that he remain in the Marine Corps but feared that if she told him this he would get the feeling that she did not want him. . . . This matter was thoroughly discussed with Mrs. D. who agreed to have the department contact Edward's chaplain and commanding officer about it.

Later in the month another call was made:

> Mrs. D. was upset and nervous. Since the department had written to Edward's commanding officer, Edward had been sending letters home complaining about his life in the service and complaining that his mother would not have any consideration for him. She had not cooperated in helping him to get out of the service.

The following month Edward returned home on a 2-week furlough during which time:

> Plans for Mrs. D.'s future needs were discussed with Mrs. D. and Edward. Edward said that he would still like to get out of the Marines and come home to be with his mother but admitted that he had no plan of helping her if he should come home. Worker discussed with him the advisability of making a dependency allotment for his mother. He said that he had already discussed this with his commanding officer but did not feel he could increase the allotment of $30 which he is making at the present time. (First payment had been delayed.)
>
> Mrs. D.'s financial needs were explained to Edward. Worker pointed out to him that should he feel that he could make a dependency allotment of $50 a month, the Government would then add another $60, making a total of $110, which when added to the social security payments Mrs. D. will begin receiving in March would give her a total income of approximately $150 per month, a sum adequate for her needs. Worker explained to Edward that this would exceed the amount which the department can supplement. The whole family seemed to be very much interested in this possibility.
>
> Edward went on to say that he would like to see his mother get some place else to live as he feels that life in the village is hard on her. He further related that he would soon be sent overseas and that his pay would then be raised but that at present he was receiving $80 per month out of which payment he had to buy all his own clothing and pay for laundry and cleaning. He promised to think over worker's proposal and said that as soon as he went overseas, he would give the plan serious consideration.

Another effective type of help which the worker can provide, particularly in early contacts, is through anticipating pitfalls or situations of potential stress for the family and to make her services available in advance of or at the time the trouble is most likely to occur. We see an illustration of this in the D. case when the worker, knowing Mrs. D.'s lack of experience in management, especially of a sizeable sum of money, helps her anticipate what she will do with her first social-security check.

> . . . Worker informed Mrs. D. that she would get an initial payment of about $300 and the first payment would be made sometime in March. . . . Plans for the use of this initial payment were discussed with Mrs. D. She said that, if possible, she would like to purchase a washing machine with part of the money. She was informed that this would be agreeable to the agency and was urged to come into the office to discuss her plans for the use of the money upon receipt of payment.

This timely use of relationship is further illustrated in the worker's visit to the family when Edward was home on furlough so that she might support both Edward and his mother in carrying out the plan for Edward to remain in the Marines and to assume responsibility for his family. This kind of help, involving only a small but strategic investment of worker's time, is both protective and preventive for it may keep much more serious and time-consuming problems from arising.

## *The Helping Role*

Space does not permit discussion of some of the other uses workers are making of the casework relationship in the eligibility process to contribute to the strengthening of family life. The concepts illustrated here, however, are sufficient to show that public-welfare caseworkers have reached a significant understanding about the use of the casework relationship. This is that all situations in which workers and clients meet in joint activity provide workers with opportunities to help people function more effectively no matter what the overt activity may be in which the workers and client are engaged.

Viewed in this light, "determination of eligibility" becomes much more than a self-contained process beginning with an application and ending with denial or acceptance for a grant. It is the beginning of the helping role through which the worker encourages parents and children to learn how to use their capacities for more productive and independent living.

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[1] Wisconsin Department of Public Welfare. Case record (disguised for publication).

# PRENATAL NUTRITION AND INFANT HEALTH

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IN THE UNITED STATES the past 50 years have brought a gratifying decline in the number of deaths occurring in babies under one year of age. In 1956 only about one-fourth as many babies died for each thousand babies born alive as had died in 1915. But the number of babies dying at less than a week of age has not declined nearly as rapidly as the death rate in older infants. Babies who die before they are a week old now make up the largest share of all infant deaths under a year of age. A majority of these early deaths occur in infants born prematurely.

There are many causes of early infant death; some of them we can as yet do little about. We can try to find out why babies are born prematurely and work to eliminate these factors. Every baby is entitled to his full time in his mother's uterus; it is his best insurance for a healthy infancy. Not only are premature babies apt to be frail babies, but the danger of birth injury is greater for them.

Careful study in many countries and with many types of investigations makes it seem certain now that one big factor concerned with premature delivery is the poor state of the mother's nutrition and health even before she is pregnant. Poor nutrition during pregnancy itself only makes the situation worse.

The great tragedy is that much of this poor nutrition among mothers and mothers-to-be is unnecessary. Better judgment in buying the family food often would provide good nutrition for the entire family at no increase in cost. Stuart and Burke in Boston observed that when nutrition during pregnancy was inadequate, the fetus suffered to a greater degree than the mother.[1] Mothers whose protein intake was low gave birth to smaller and lighter-weight infants than did well-fed mothers.[2] It is well known that strong babies are easier to care for than are weak babies.

### Poor Food Habits

Studies of food habits of low-income pregnant women in Iowa [3] showed that, in that State, very few pregnant women did not get enough food. A far higher percentage of these women ate too much, yet were poorly nourished because of poor choice of foods. They became fat, yet were malnourished. Their food habits were such that the normal amount of calories had not provided enough of the necessary nutrients, so they felt unsatisfied—the "hidden hunger" of the malnourished.

Unfortunately, we humans do not know instinctively what foods we need most, so we eat more of the same foods we are accustomed to. Thus in Iowa some pregnant women were getting enough of each nutrient studied, at the expense of getting fat from too many calories. Many others just got fat, but were still malnourished, because even double the amount of the foods they liked to eat did not provide the essential nutrients.

Very few of these pregnant women got enough calcium for their own bones, not to speak of getting enough for the baby's. Almost as many ate far too little protein. Of the common vitamins, riboflavin and vitamin C were in short supply for many. A quart of milk a day would have given the great majority of these women sufficient added calcium, protein, and riboflavin to have made their supply of these nutrients ample. More fruit or fruit juices and salad vegetables would have improved their vitamin-C intake. Unfortunately, they turned to more baked goods to satisfy their hunger, often at much greater financial cost than the milk and fruit. Only because the flour was enriched the women got sufficient iron and thiamine and some riboflavin from the large amounts of breadstuffs they ate.

All of these women were eating the same foods as they had eaten since childhood. They had not altered their general diet pattern. That is generally true. Meal patterns tend to go on in families for generations, modified a bit in each generation by the likes and dislikes of the husband. Unfortunately such modifications are usually downward. Foods not liked by either member of the young family are omitted and often no substitution is made. So the number of foods eaten grows steadily less and the family nutrition suffers.

But that is not all of the story. Studies of school-age children show that grade-school children can be taught what foods they need to eat and they will learn to eat them both in school lunches and at home.[4] High-school boys will generally eat almost every food available. High-school girls, however, are socially conscious, afraid to eat for fear they will get fat or have poor complexions, yet torn by the urge to go with the crowd and eat as the crowd does in its special "hangouts." The boys will go home after such snacks and still eat a full meal at home, but the girl tends not to eat her meals at home if she has snacked after school. Then she is hungry again before bedtime and snacks again. Unfortunately such snacks rarely provide much besides calories and the girl's nutrition suffers at the time she most needs a good diet to complete building her own body.

### *Effects on Pregnancy*

If she follows a nutritious diet over several months, such a girl can achieve good nutritional status. But if her poor eating habits continue, she does not really complete building her own body until many years after growth has stopped. Many girls marry and start a family at a young age. With their own bodies incomplete, they have to build both a new body and also sufficient muscle and other tissues in their own bodies to carry the fetus and to deliver it. The young mother tries to do all this without changing her food habits, except in regard to quantity. It is no wonder that many come to grief.

In the Iowa study of pregnant women, it was observed that the well-nourished women delivered prematurely only when they had twins, or had had five or more babies at closely spaced intervals.[5] In either case, the babies were usually in good condition and only a pound or so under the weight which marks prematurity. All the babies thrived.

On the other hand, in the same study the group whose diets were poorest were most apt to deliver prematurely, and most of them were young mothers, delivering their first to third child. All of these babies were single births; there should have been no excessive load on the mother had she been well nourished. Since premature delivery might be nature's way of sparing the mother a burden beyond her capacity, it seems that these young women's bodies were poorly equipped to provide nourishment for a new life.

The study also showed that the prematurely born babies of the poorly nourished mothers were smaller and weaker than those prematurely born to better-nourished mothers. Several of these very small babies were not strong enough even to live, despite modern care and feeding. Some of the babies were malformed. There are many causes of malformation. Poor nutrition is one cause, difficult to prove for humans but well known in animal studies.[6] Though poor nutrition is not yet proved as a cause of congenital malformations in human infants, the likelihood that it does cause malformation is so great and the preventive is so simple that no mother should take the risk. Had the young mothers of our study been better nourished, more of the babies probably would have been carried to term and would have lived; those who lived would have been stronger; and it seems possible that some, at least, of the deformities could have been prevented.

Studies of adolescent girls in Iowa[7] showed that previous nutritional status affected their ability to utilize nutrients when they were given a good diet. Girls who had been well fed through midchildhood were able to retain ample amounts of the nutrients provided in good diets. Girls who had been poorly nourished through midchildhood were unable to utilize the nutrients of a good diet, especially such nutrients as calcium, which are not easily absorbed. Several months of good feeding were necessary to make these girls as efficient in use of their food as were the well-nourished girls. Once they achieved that improved efficiency they maintained it easily. Both groups of girls were adversely affected by emotional disturbances. Retentions dropped sharply when the girls became overexcited.

Many girls have their first child in mid-teens,

### FOOD RECOMMENDATIONS FOR WOMEN
### Nonpregnant and Pregnant

excerpted from
Food and Nutrition Board, National Research Council
Recommended Daily Dietary Allowances, Revised 1958.

Designed for the maintenance of good nutrition of healthy persons in the United States. Allowances are considered to apply to persons normally vigorous and living in temperate climate.

| | Nonpregnant, age 25, weight 128 lb., height 64 in. | Pregnant (2d half of pregnancy) | Lactating |
|---|---|---|---|
| Calories.......... | 2300 | +300 | +1000 |
| Protein (gm.).... | 58 | +20 | +40 |
| Calcium (gm.).... | 0.8 | 1.5 | 2.0 |
| Iron (mg.)....... | 12 | 15 | 15 |
| Vitamin A (I. U.) | 5000 | 6000 | 8000 |
| Thiamin (mg.)... | 1.2 | 1.3 | 1.7 |
| Riboflavin (mg.) . | 1.5 | 2.0 | 2.5 |
| Niacin[1] equivalent (mg.)...... | 17 | +3 | +2 |
| Ascorbic acid (mg.).......... | 70 | 100 | 150 |
| Vitamin D (I. U.).......... | ...... | 400 | 400 |

[1] Niacin equivalents include dietary sources of the preformed vitamin and the precursor, tryptophan.

while they are still unstable emotionally. It seemed probable to Iowa nutritionists that added emotional problems of marriage and early pregnancy could only worsen the nutritional state of a girl already poorly fed. Therefore we studied the ability to retain nutrients of girls of 14 and up who were illegitimately pregnant. The majority of the group came from homes wherein an illegitimate pregnancy would cause emotional concern.[7] However, two of the girls, who were socially immature and of low intelligence, showed no signs of distress about their pregnancy. Both of these girls had been poorly fed before the study; yet both were able to retain ample nutrients for their infants and for themselves. The girls who were worried or distressed over their circumstances did not utilize their food as well; one girl, almost despondent over her situation, lost nutrients heavily from her own body and ended her pregnancy with her own skeleton having lost twice the minerals needed by her infant.

These findings suggest that: (1) if the young mother is emotionally stable, she is apt to be in an excellent position to improve her own nutrition, as well as her baby's, by eating a good diet during her pregnancy; (2) the favorable effect of pregnancy hormones on increasing the absorption and storage of needed nutrients by the pregnant woman can be wholly nullified by serious emotional problems in the pregnant mother.

Using a different approach, a group of obstetricians in Aberdeen, Scotland, studied the effects of the lifetime nutrition of the mother on the physical state of her baby.[8] They started with the assumption that girls who had been poorly fed since infancy would be more apt to be stunted and would not be as strong as girls who had always been well-nourished. They divided all the mothers of first-born children born in the city in one year's time, about 3,500 of them, into three groups according to height, and subdivided each group according to general health. Then they listed the result of pregnancy among the women of each group.

In the study the lowest rates for prematurity (32 per 1,000 live births) and for deaths during the first week of life (19 per 1,000 live births) were found among the infants of the taller women in good general health. Infants of mothers in each group studied showed steadily increasing prematurity and death rates as the height and health of the mothers decreased. The poorest group, women under 5 feet 1 inch, who were in unsatisfactory health, had the highest rates (152/1000 and 64/1000, respectively) for premature delivery and early death of infants. Poor nutrition throughout the mother's life had increased the chance of prematurity in her infant five times, and more than tripled the chance of his death before one week of age.

## *Changing Habits*

The evidence is strong that the best insurance any baby can have for life and health is to be born of a mother who has been well nourished all her life. Thus, improvement in nutrition of prospective mothers at any age, if maintained, will result in improvement in infant health. Certainly it would be easier for a young woman to drink a quart of milk and eat more fruit and vegetables during pregnancy than to care later for a frail baby, susceptible to infections and difficult to feed.

Malnutrition is, of course, not the only cause of premature delivery by a mother. It is, however, easily preventable at moderate cost. Daily ingestion of adequate amounts of nutritious foods by girls and young wives would decrease strikingly the incidence of prematurity in their infants. The foods needed include milk (or dry nonfat milk solids), organ and other meats (the cheaper cuts of meat are just as nutritious as the more expensive ones), cheese, eggs, fruits, and vegetables, including salad and other greens. Such foods can be purchased as cheaply as the cakes, pie, and fancy rolls too often purchased instead.

No one wishes to change his or her settled food habits; the advantages of change must be made very clear. The greatest advantage is most obvious to the young pregnant woman—the health and vigor of her coming baby. Then, if ever, the young mother will be interested in improving her diet. She finds this easier and has a better foundation on which to build if she has had good food habits in her early life.

However, the most difficult problem is to reach the adolescent girl. Appeal must be made to beauty, not health, for these girls, and nutritious foods must be made as easy, or easier, for them to get as are foods of poor quality. If fried starchy foods and soft drinks only are available at the teen-age "hangout" those are the foods they will eat, to the exclusion of more nutritious foods served at home. Yet it is most important that the adolescent girl be maintained in good nutrition, if she is to arrive at pregnancy with her own body completed and with sufficient stores to provide ample nutrients for her infant during the critical first weeks of pregnancy when the separate organs are forming.

No discussion of improvement in nutrition of mothers-to-be is complete without mention of the role of the young father-to-be. When the young pregnant woman is given dietary advice, the common answer is: "I can't. I'd have to cook two separate meals, for my husband eats so few of these foods." Sadly enough, they speak the truth. Though foods are so plentiful in this country, children are allowed to grow to maturity eating only a few foods, and those cooked in one or two ways.

A potent argument for the young husband is to remind him that the coming baby is his, also. It is his wife's duty to eat what she needs to bear a sturdy infant and it is his duty to see that she does. Taking this responsibility will not injure him in any way, and it may even help the next baby. If an expectant father is asked to become guardian of his wife's diet, he usually assumes the responsibility, though it forces him to taste and to eat many foods he has never tried to eat before. After several months of eating well-balanced meals, the two young people have learned that they both feel better and are stronger than with their old haphazard ways of eating. Another family has started on the road to good nutrition.

Priceless gifts for a family to pass on to a child are a strong, well-nourished body and good food habits. A new family tradition of food habits, this time habits of choosing foods that lead to good nutrition, can be started best when a new family is starting. The mother who teaches her boys as well as her girls the wisdom of good nutrition, the proper rating of different foods according to their nutritious qualities, and the value of learning to eat a wide variety of foods to insure adequate intake of all nutritional essentials is upgrading the nutrition of her community and that of its unborn children.

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[7] Jeans, P. C.; Stearns, G.; et al.: Unpublished data.

[8] Thomson, A. M.: Technique and perspective in clinical and dietary studies of human pregnancy. *In* Proceedings of the Nutrition Society. British Nutrition Society, London: Cambridge University Press, 1957.

**Children cannot remain in cold storage while nations tackle other problems of industrialization.**

*Charles I. Schottland to the International Conference of Social Work, Munich, 1957.*

# IN THE INTEREST OF CHILDREN

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THE REPORT of the Conference on Family Casework in the Interest of Children[1] sponsored jointly by the Family Service Association of America and the Elizabeth McCormick Memorial Fund is another milestone in the growing unity of approach to the problems of human behavior in the fields of the social sciences, psychiatry, and social work. One cannot in a review of this report, contained in the February–March 1958 issue of *Social Casework*, attempt to give a resumé of each of the papers and workshop discussions presented nor hope to do justice to the contributions of the many participants in the conference. The authors represent many fields, including anthropology, sociology, social research, and psychiatry, as well as social work.

The papers give abundant evidence of the increasing utilization in social work of the social sciences. The relationship between the social sciences and social work has followed a circular path from the days when social work looked upon itself as an applied social science. The subsequent devotion to new concepts and insights derived from the fields of psychology, psychiatry, and psychoanalysis alienated social work from its distant beginnings. Social workers are now, with fuller understanding, utilizing the help of the social sciences in relating their efforts more basically to the social and cultural currents and developments of our time.

One might have wished that the interdisciplinary concept of the conference might have extended within the field of social work itself to have included workers from the fields of child guidance and child welfare. It might have added to the rounded picture of services to families and children. This might also have signified more the growing maturity of the social-work profession. Social work has, for the most part, now passed through an adolescent period in which its various specializations have had to strive to establish and preserve their own identities and individual differences. We can now observe within these specialties a growing acceptance of likeness as well as differences and a unity of interest and practice.

From the cross section of current practice and thinking in family casework presented in the report, particular mention must be made of the article by the late Robert Gomberg, "Trends in Theory and Practice," in the section on Family Diagnosis. In this article Dr. Gomberg sets a framework for the subsequent discussions of treatment methodology and research and projects some future goals. His general theme, and that of many of the other papers and discussions, is a plea for developing a theoretical framework for family diagnosis. In fact the report as a whole points up the crying need for some system of classification for family units.

Currently, the field of social work and related disciplines must rely on diagnostic systems in which the individual personality is the clinical entity studied and in which the evaluation of functioning and the range from normal to pathological is related to individual personalities. This system is inadequate as a suitable tool for the study of family interaction and the diagnosis and treatment of family disorders. In his paper Dr. Gomberg mentions some suggested approaches to evolving a conceptual system of family typologies. He refers particularly to the work of Nathan Ackerman, who has suggested a system for evaluation embracing three sets of processes: what goes on within the individual; what goes on between the individual and other significant family members; and the psychosocial patterns of the family as a whole.

In recent years psychiatrists and sociologists have been stressing the concept of homeostatic mechanisms or the methods by which family units maintain balance in their social and psychological adaptations within their family milieu and their social milieu. They regard determination of family dysfunctioning as related to the family's capacity for maintaining balance in the relationships within the family as well as in relation to external stresses, pointing out that varying degrees of disequilibrium are related to varying degrees and qualities of stress bearing on the family from within and without. Ruben Hill's article, "Social Stresses on the Family," in this report makes some suggestions for a conceptual framework within which to review families in crisis and sets up three systems of classification of family troubles.

These papers and other recent literature indicate that various workers in social work and related disciplines are approaching the concept of the "well" versus the "ill" family with more refined definitions of family adaptation. These will undoubtedly lead soon to a usable system of classification and typology.

### *Child Guidance and Child Welfare*

Participation in the conference of persons from the field of child guidance and child welfare might have emphasized what is becoming increasingly clear to workers in the child-guidance, child-welfare, and family-service fields: the moving together and even overlapping of the day-to-day functioning of family-casework, child-guidance, and child-welfare services in regard to children living in their own homes. Workers serving children more and more see the need for tools of family diagnosis. Increasingly they are emphasizing the necessity of work with the total family in the interest of the child's emotional development. They have accepted the hypothesis that a child's personality difficulties are an integral part of the disorder of the total family. They have seen how balance in a neurotic family can be dependent on the continuance of individuals' illnesses and have witnessed the disequilibrium which can be brought about by changes in one family member.

There can be no question of the values in child-guidance practice of work with all family members towards restoration of healthy family life along with the treatment of individual personality disorders. Family agencies, child-welfare agencies, and child-guidance clinics deal with problems of family interrelationships and have as a primary purpose of their work helping parents discharge more adequately their child-rearing functions.

In regard to the question of direct treatment of children in family agencies, Sidney Green, in an interesting article, "Clinical Considerations in Determining Goals and Techniques," defines one difference between the child-guidance clinic and the family agency as:

> The family service agency has a primary interest in maximizing the adequacy of total family functioning and elects to work initially with those individuals deemed most likely to help achieve this goal. Its primary aim is to help these individuals in terms of improved social adaptation in the home and in the community at large. The child-guidance clinic is primarily concerned with restoration of healthy internal emotional stability in individual children and is concerned with family life mostly to the extent that family life interferes with or supports the conduct of the child's psychotherapy. . . .

Undeniably this has been the traditional differentiation between the family agency and the child-guidance clinic. However, workers in child-guidance services are being forced out of this traditional approach by the recognition that the child can no longer be regarded as the primary client with other members of the family being offered auxiliary services only. Service must be offered to the family unit with each member of the family receiving the treatment of choice, be it guidance, educational help, or psychotherapy. This is particularly true in the case of the preadolescent child.

Child-guidance clinics, and perhaps the child-welfare and family agencies too, have been remiss in their services to families by neglecting the fathers as participants in the service being offered family units. The parent-child problem dealt with in the family agency has most frequently been the mother-child problem. Similarly the traditional child-guidance approach is to work with mother and child. However, the father is now being recognized as a member of the family. This is giving more reality to the concept of family-oriented treatment. But much discrepancy still exists between theory and practice.

In her article, "Considerations for Involving Children in Direct Treatment," Frances H. Sherz agrees with other members of the workshop that the family agency can be an appropriate treatment resource for the problems of the child in the latency period (approximately ages 6 to 10) who does not present severe maladjustment difficulties. She emphasizes the need for training the family caseworker to undertake such direct treatment as well as to utilize psychiatric consultation. She distinguishes between the respective abilities of family agency and child-guidance clinic to deal with varying disorders in children, emphasizing particularly that the child-guidance clinic has facilities for deeper exploration and investigation of a child's disturbance and has staff trained to deal with the more severe disturbances of childhood and to give more intensive forms of child therapy.

### *Meeting Service Needs*

It would be ostrich-like of us to believe that such criteria for channeling the increasing number of clients coming to the family agencies for help with parent-child problems are not merely theoretical and can be faithfully applied. We in child-guidance, child-welfare, and family service have all been struck by the apparently tremendous increase in the numbers of severely disturbed children. Whatever the reasons for this, we are faced with the enormous task of finding diagnostic and treatment services for the greatly increased child populatiton needing help. The increase in child-guidance and psychiatric clinic resources has nowhere kept up with the demand for services. The family agencies, as the so-called "general practitioners" in the field, find themselves in the position of dealing with demands for services to families not able to penetrate the waiting lists of clinics. They are working with families of severely disturbed children, if not with the children themselves, as well as with an increasingly severely disturbed adult clientele.

Perhaps we should begin to conceive in a more formal way of the family agency as the general practitioner in the field of social work. This could, perhaps, be the service of first resort for parent-child problems as well as for families under stress for other reasons. The family agency would then be responsible for making the initial family diagnosis, determining the treatment needs of the family unit and its individual members, and separating out those families who need the more specialized services of the child-guidance clinic, psychiatric clinic, or other specialized agencies. Social work would, of course, have to be oriented to providing the increased training for caseworkers and the increased diagnostic and clinical services now already part of many family-service agencies.

Child-welfare workers also are increasingly stressing the need for work with the total family. They too must see their clients not primarily as children but as family members and must take responsibility for working with the natural family whether the child is in his own home or in placement. Too often only lipservice is paid to these oft-stated principles. Too often discouragement with the limited potentialities of some families prevents child-welfare workers, as well as child-guidance workers, from accepting a role with the total family. Although there is increasing work with children in their own homes in the child-welfare field, in foster care too often work with the natural family is not begun until the time of planning for a child's discharge from placement—too late, unfortunately, to make an adequate contribution to the restoration of family health.

The adequacy of services to the child and family on the child's return from placement also needs evaluation. The aftercare function of the children's agency is an area of service which merits consideration for a larger place than it occupies in agency budgets and caseloads.

Family-agency, child-guidance, and child-welfare workers must view themselves in the role of "family workers." We can no longer remain separate in our identities but must more and more share a common function in working in the interests of the child and his family.

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[1] Family Service Association of America, New York: Family casework in the interest of children. Social Casework, February–March 1958.

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> The older child who fights his parents is engaged in a wholly human activity, in which he explores a great range of human emotion in miniature. He cannot be trained to behave without a quiet place in which to pursue this rehearsal of the real stuff to come. Indeed, what he experiences *is* the real stuff, but he is not expected to stand or fall by the results, as he will have to later in his life.
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> *"Parents and Children Yesterday and Today," Mildred Creak, M. D.,* in The Lancet, *July 31, 1954.*

# BOOK NOTES

THE FAMILY IN A MONEY WORLD. Frances Lomas Feldman. Family Service Association of America, 215 Fourth Avenue, New York 3, N. Y. 1957. 188 pp. $2.50.

Addressed to social-welfare agencies whose workers counsel families about budgeting and other financial problems, this book presents information on money management, based on a study to which representatives of a number of fields—social work, sociology, anthropology, psychiatry, law, economics, and home economics—contributed. The first six chapters discuss relationships between the economic, social, cultural, and psychological meaning and use of money. The next four deal with aspects of budget counseling and related services. The last four take up basic budget items, savings, family resources and liabilities, use of credit, and budget planning, and include guides for applying the information to specific cases.

THE MENTALLY RETARDED CHILD: development, education, and guidance. Max L. Hutt and Robert Gwyn Gibby. Allyn & Bacon, Boston. 1958. 334 pp. $4.50.

Addressed chiefly to teachers and parents of mentally retarded children, but also to physicians, group leaders, psychologists, social workers, and religious leaders, this book, written by two psychologists, is aimed at spreading the increased knowledge about the retarded child that has been gained during the past decade.

Drawing on results of many research studies, the authors stress the fact that the retarded child's pschological development follows the same principles as does that of the normal child. They also point out that the retarded child shows no behavioral reactions that other children do not have, but that he is more prone to show maladaptive reactions and to continue them longer.

Mental retardation is not an entity, the authors maintain, pointing out that it involves "somatic processes, internal psychological reactions, social and cultural forces, and intricate interpersonal relationships." The mentally retarded child, they note, has various problems—medical, psychological, educational, vocational, social, and other—and these need the attention of many kinds of workers besides the traditional team of physician, psychologist, and social worker who staff the mental-retardation clinic.

The book discusses the emotional problems of parents of retarded children and suggests methods for alleviating these problems.

LOVE AND CONFLICT; new patterns in family life. Gibson Winter. Doubleday & Co., Garden City, N. Y. 1958. 191 pp. $3.50.

In this book the author, a sociologist, defines the modern American's conflict as a "need for understanding and affection and a shrinking ability to receive them." Regretting the removal of all restraints by many parents today, the author maintains that imposing order in the home is a form of love, since it expresses the parents' concern for the children's growth.

However, he maintains that the present-day picture of the increasing "revolt of youth" should not be exaggerated, for the majority of the young are trying to find their way through "a bewildering array of new expectations." He urges parents to guide their children through the transition period—out of the family, through school, to part-time employment, and then to regular employment and an independent existence. Throughout the book the author stresses the importance of religion in family life.

BIOGRAPHY OF A FOUNDATION. William C. Richards and William J. Norton. Children's Fund of Michigan, Detroit. 1957. 195 pp. Single copies available on request.

Twenty-five years of starting and encouraging projects for child health and child welfare, most of which became self-sustaining, are reported in this account of the work of the Children's Fund of Michigan, founded in 1929 by the late Senator James Couzens of Michigan and continuing until 1954, as originally planned. The book reports that the Senator's gifts to the Fund, including earnings from its investments, amounted to more than $18 million.

Among the Fund's accomplishments, as described by the authors, were establishment of county public-health departments, child-guidance clinics, rural pediatric clinics, programs for dental research and treatment; a medical research laboratory; a nutrition program, a summer camp and other services for crippled children; and a system of traveling libraries.

HEALTH AND MEDICAL CARE IN NEW YORK CITY; a report by the committee for the special research project in the Health Insurance Plan of Greater New York. Published for the Commonwealth Fund by Harvard University Press, Cambridge, Mass. 1957. 275 pp. $7.50.

The study reported in this book was designed to examine the medical experience in 1951 of two samples of New York City's population: one consisting of families in which one or more members were enrolled in the Health Insurance Plan of Greater New York; the other, of families comparable in other respects with the first group, but not covered by the plan.

The book sets forth statistical comparisons between the two groups on such factors as morbidity, disability, and medical care; hospital experience; contacts with physicians; and pediatric services. It shows, for example, that 69.0 percent of the persons enrolled in the plan were reported to have received medical care in 1951, including preventive services, but only 56.6 percent of those not enrolled. A more pronounced difference between the two groups is reported in the proportion of families that obtained services from a "special doctor for children," not necessarily a diplomate in pediatrics. In a sample consisting of 622 enrolled families, with 846 children under 6 years of age, 63.3 percent had obtained such service, but in a sample of 942 families not enrolled, the percentage was only 42.3.

# IN THE JOURNALS

## *They Like It Hot*

Except for increased water requirements, hot weather does not require changes in the diet of healthy infants and children, say two Texas pediatricians, writing in the *Journal of the American Medical Association* for April 26, 1958. ("Feeding of Infants and Children in Hot Weather," by Floyd A. Norman and Edward L. Pratt.) Basing their statements on the experience of a number of pediatricians practicing in areas where long periods of hot weather occur, the authors maintain that if a child on a well-balanced diet suffers from heat he is probably ill, and the family doctor should investigate his condition.

The authors suggest that vigorous outdoor play is needed, that children should drink cool water rather than high-calorie drinks, which, like ice cream and other high-calorie foods, reduce the appetite for well-balanced meals; that a short cooling-off period before meals may increase the child's appetite, and that all the usual measures for developing good eating habits should be continued, irrespective of the weather. They add that children do not dislike hot weather unless adults' example leads them to do so.

## *Food and Speech Therapy*

A plan for giving a cerebral-palsied child an adequate diet while helping him develop the muscles used in eating and talking is suggested by a speech therapist and a nutritionist in *The Crippled Child* for April 1958. ("Feeding Techniques for Health and Speech," by Donna Russell Fox and Barbara Shuffield McDonald.)

Many a cerebral-palsied child is kept too long on a soft or liquid diet, the authors note, maintaining that such a child, like other children, needs a variety of solid foods and that the parents should give him these when the physician considers it safe.

As a step toward enabling the cerebral-palsied child to eat the recommended foods, the authors list such foods and suggest ways of feeding the child so as to help him develop the muscles of the cheeks, jaws, and tongue, which he will also use in talking.

## *Clothes Like Other Children's*

Some readymade clothing can be altered slightly to permit a disabled child to dress and undress himself as well as other children of his age, according to Moira M. Ward, writing in the *American Journal of Nursing* for April 1958. ("Self-Help Fashions for the Physically Disabled Child.") In considering the special clothing needs of a disabled child, says the author, it is necessary to consider first the degree, type, and extent of his disability; any ability he has left, no matter how small, is a help, she says.

Emphasizing the fact that children want to wear clothes like other children's, the author urges that insofar as possible ordinary clothes be purchased for the disabled child, and if necessary altered. Among the garments that can serve without alteration are listed: T-shirts, which the author says most disabled children can put on and off easily; skirts and slacks with elasticized waistbands; and for girls who spend much time in a wheelchair, wraparound skirts. For other clothing, alterations suggested include elasticizing waistbands of girls' pinafores (worn with T-shirts), sewing up the openings of button-in-back dresses (leaving the buttons) and adding a front opening with a concealed zipper. For boys who wear braces the author notes that trousers with zippers on the outside seams will cover the braces.

## *Effects of Permissiveness*

Some results of a 4-year study to determine similarities and differences between children of permissive and of strict families are reported by Goodwin Watson in *McCall's* for May 1958. ("The 'Spoiled' Child.")

The study, made by psychologists, social workers, and teachers, and supported by Columbia University's Council for Research in the Social Sciences, sought information on such characteristics as creativity, independence, and socialization in 38 children 6–11 years of age from strict families and an equal number of those from permissive ones.

After giving each child a battery of tests, the investigators rated one-third of the children from permissive homes as "highly creative, spontaneous, original," but could describe in this way only one-twentieth of those from strict homes. On tests for self-reliance 6 to 1 of the children in the permissive group received a rating of "independent"; in the group from strict families the ratio was 4 to 1. As for ability to get along with people, the author notes that "the most socialized, cooperative, and best-accepted youngsters came (by a ratio of 3 to 1) from permissive homes."

Children from the two types of homes, the investigators found, were remarkably similar in energy and in apparent feelings of security and happiness.

In both the strict and the permissive groups only families were included in which both parents were living with their children, in which the children were wanted and loved, and in which no child had been delinquent or referred for psychiatric treatment.

The investigators had planned to include 50 children in each group, the author says, but only 38 consistently permissive families were found in the suburban community where the study was made.

## *World Child Welfare*

Since effective machinery for carrying out any governmental policy for child welfare must vary according to the country's socioeconomic status, legal system, and other factors, no model for such machinery can or should be prescribed, says an article in the *International Social Service Review* for October 1957. ("Organization and Administration of Child-Welfare Service.")

The article outlines a variety of organizational patterns for child-welfare services provided by central, State or Provincial, and local governments. Countries whose plans are noted include Israel, Egypt, Chile, Panama, Sweden, Norway, Denmark, Finland, Iceland, the United States, the United Kingdom, Yugoslavia, and Japan.

Various devices are described for coordinating child-welfare work of public agencies and voluntary organizations in India, Pakistan, Egypt, El Salvador, Belgium, the United States, and Canada.

## *Training Attendants*

A course for attendants in an institution for mentally retarded children is described in the March 1958 issue of the *American Journal of Mental Deficiency* by a psychologist who was responsible for the course and who taught about half of it. ("The Psychological Development of the Mentally Retarded Child; a Training Course for Attendants," by Winifred S. Graves.)

The course, which is given repeatedly at the Columbus (Ohio) State School, includes film showings depicting the physical, emotional, and social development of normal children; descriptions by a physician of types of defects found in retarded children; and demonstrations by hearing and speech therapists of ways that attendants can help children who have these physical handicaps. One session is devoted to the care of wheelchair patients and others with severe physical handicaps. At this session a cerebral-palsied teacher whose arms and legs are paralyzed has joined with an occupational therapist in helping the attendants to understand these patients' special problems.

## *Blind Children*

Eighty-seven percent of blind school children lost their sight before they were 5 years of age, and more than 50 percent were blind when they were born, according to information for the school year 1954–55 collected by the National Society for Prevention of Blindness and reported in the spring issue of the quarterly, *Sight-Saving Review*. ("Causes of Blindness in Children of School Age," by C. Edith Kerby.)

In at least 40 percent of the whole group of blind school children the cause was reported as "unspecified prenatal influence." But the author states that if all infants showing evidence of congential eye defects were studied intensively soon after birth, more of the blindness might be found due to a known cause, such as heredity or an infectious disease affecting the mother during pregnancy. Sufficient family history was available, the report notes, to indicate that 14 percent of the blindness in the school children could be presumed to be due to heredity.

The report shows a generally downward trend in the rate of blindness among school children during the more than two decades since the first study in this series was made. The reduction, the figures show, is due to a substantial decrease in the rate of blindness due to infectious diseases, especially ophthalmia neonatorum and syphilis, and to injuries.

The information reported is based on diagnostic records of 4,426 children in grades from kindergarten through senior high school in the continental United States and the Territory of Hawaii.

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# Guides and Reports

AN APPRAISAL OF THE LONGITUDINAL APPROACH TO STUDIES OF GROWTH AND DEVELOPMENT. Dankward Kodlin and Donovan J. Thompson. Monographs of the Society for Research in Child Development, Vol. 23, Serial No. 67, No. 1. 1958. Child Development Publications, Purdue University, Lafayette, Ind. 47 pp. $1.75.

Describes some phases of the programs for longitudinal studies of children's growth carried on at the School of Public Health, Harvard University; the Fels Research Institute; and the Child Research Council, Denver, Colo. Compares longitudinal with cross-sectional approaches.

READINGS FOR HOUSEPARENTS OF CHILDREN'S INSTITUTIONS. Edited by the staff of the Group Child Care Project of the Southeastern Conference of Workers in Children's Homes and the School of Social Work, University of North Carolina. Published by Materials Center for Children's Institutions, Werkman's Book House, 350 West 69th Street, Chicago 21, Ill. 1958. 94 pp. Single copies 80 cents; 10–24 copies, 72 cents each; 25 or more, 60 cents each.

Includes 23 short articles for use in inservice training or for house-parents' individual study.

ALL CHILDREN HAVE GIFTS. Anne S. Hoppock. Bulletin 100. Association for Childhood Education International, 1200 15th Street, Washington 5, D. C. 1958. 32 pp. 75 cents.

Offers guidelines toward helping each child discover and develop his own creative abilities, on the theory that every child has a contribution to make to the development of a democratic culture.

THE SHORT-TERM CASE IN THE FAMILY AGENCY. Institute for Welfare Research, Community Service Society of New York. Family Service Association of America, 215 Fourth Avenue, New York 3, N. Y. 1957. 42 pp. 80 cents.

Presents three papers on research concerning family service cases in which only one interview took place between the client and the social worker.

EIGHTY-FOURTH FORUM OF THE NATIONAL CONFERENCE OF SOCIAL WELFARE, PHILADELPHIA, MAY 19–24, 1957

PROCEEDINGS. Columbia University Press, New York. 1958. 280 pp. $5.

Twenty papers selected from the several hundred given at the conference on the basis of their timeliness or pertinence for the future.

CASEWORK PAPERS. Family Service Association of America, New York. 1957. 158 pp. $2.50.

GROUP WORK PAPERS. National Association of Social Workers, New York. 1958. 82 pp. $1.75.

NEW APPROACHES TO ADMINISTRATION AND RESEARCH IN SOCIAL WORK EDUCATION. Council on Social Work Education, New York. 1957. 41 pp. 50 cents.

combination of specialized knowledge and skills not included in legal education and experience and is therefore not a proper function of an attorney.

# HERE AND THERE

## *Latin American Conference on Nutrition*

A series of symposia on child nutrition was conducted in February and March in various parts of South America by the Inter-American Children's Institute and the Unitarian Service Committee, with the cooperation of several international organizations.

Original plans called for a meeting in Colombia, at the Medical School of the Universidad del Valle in Cali, and one in La Paz, Bolivia, sponsored by the Pediatric Society and the Social Security Institute. However, interest created was so great that the Governments of Argentina and Brazil organized two additional symposia, attended by experts from every Province and State of those countries.

An interprofessional team of South American experts appointed by the Inter-American Children's Institute—a specialized agency of the Organization of American States—and one of North American experts, provided by the Unitarian Service Committee, coordinated discussions. They included medical and public-health educators, nutritionists, anthropologists, and social workers. Institute grants enabled directors of nutrition institutes, pediatricians, social workers, and other professional people from every South American country to attend.

Each symposium stressed practical ways of applying present knowledge and overcoming obstacles to adequate food production, distribution, conservation, and use.

Attention was paid to emergency and short-range programs and also to long-range programs such as environmental sanitation. Lack of such sanitation is a cause of intestinal parasites and consequent anemia, which contribute to the poor nutrition of people in many South American areas.

Use of vegetable proteins and dried skim milk for emergency diets in areas lacking milk and animal protein was discussed.

A warning was sounded against the tendency throughout the Americas to shorten the period of breast feeding. It was pointed out that in these countries childhood malnutrition is most marked in the post-weaning period.

Anthropologists presented material on food habits and their meaning, particularly among Indian populations. Agricultural experts emphasized problems and possibilities in increasing food production and facilitating distribution. Nutrition experts asked for a voice in national councils dealing with food production, declaring that national plans often focus on production for export without consideration of national nutritional needs.

Emphasis was given to education at all levels, from the university down to the rural school, and through health centers, social agencies, and other services, with a plea for greater uniformity in terminology and type of instruction to families who often receive conflicting directions from different agencies and experts.

Social workers described community-development programs as a means whereby people themselves help to improve their level of living. Minimum-wage laws and measures to make needed food available to low-income groups at reasonable cost were discussed.

—Elisabeth Shirley Enochs

## *Attorneys and Adoption*

Fourteen attorneys met in Washington in early May to consider the role played by the attorney in adoption. This was the third of a series of meetings called by the Children's Bureau with members of various professions to review their roles in adoption. Prior meetings were held with social workers and physicians.

Participants in the May meeting included attorneys in private practice, faculty members of law schools, and consultants to public welfare departments and voluntary adoption agencies. They unanimously agreed that placement of children for adoption requires a

They also pointed out that since adoption is a legal process in which important rights of people are involved it requires the legal services of attorneys. Among the legal phases they mentioned in which these services are required were: help in effecting compliance with statutory requirements such as parental consent; relinquishment or termination of parental rights; residence or other jurisdictional requirements; preparation of pleadings and legal documents. They expressed approval of the protection some States offer adopted children by issuing amended birth certificates and requiring original birth records to be impounded and to be available on court order only.

Pointing out that independent adoption placements on the whole involve more risks than agency placements for natural parents, the child, and adoptive parents, the group preferred that placement be made through agencies with the possible exception of placement by a parent or placement with relatives. They recommended that in agency placements a social study to determine the suitability of prospective adoptive parents be made by a social agency before a child is placed for adoption and that the home be supervised until the adoption is final.

The lawyer must have knowledge of community resources for unmarried mothers to which he can refer those who need help with social or emotional problems, the attorneys agreed. They expressed the opinion that the more adequate the services for unmarried mothers in every community, the more quickly will there be improvements in legal practice and elimination of black and gray market placements of babies for adoption. However, they also stressed the attorney's obligation to render legal advice to the unmarried mother who seeks it, and emphasized the fact that social workers are neither qualified nor authorized to render legal services to unmarried mothers or to anyone else.

Having accepted the concept that the attorney does not place children, the attorneys pointed to the lawyer's responsibility to refer to social agencies couples seeking adoptive children. However, they insisted that a couple must secure an attorney of their own choice when the time comes to petition a court for the adoption. They questioned the practice of having a single attorney represent both the adoption agency and the adoptive parents in judicial proceedings. They defined the role of the attorney in serving as consultant to a social agency as assisting the agency to comply with legal requirements. Because of the possibility of conflict of interests, an attorney should not represent both the natural parents and prospective parents, they said.

The attorneys also stressed the need for teamwork among the social-work, medical, and legal professions, on local, State, and National levels, in working toward good adoption practice, and expressed the opinion that understanding among the three professions will result in greater protection for all parties in adoption.

They recommended that attorneys take the lead in working toward improvements on legislative changes. They urged the Children's Bureau to continue to work cooperatively with members of the legal profession and bar associations and recommended that the Bureau enlist the help of the newly formed Family Law Section of the American Bar Association.

—Ursula M. Gallagher

## *Proxy Adoption*

Adoption by American couples of foreign children by proxy is hazardous to both children and adoptive parents and tends to undermine State child-protective legislation and practices throughout the Nation, according to a report of proxy adoptions recently completed for the Child Welfare League of America and the International Social Service. Recognizing the plight of homeless children in many countries, however, the report maintains that "broad community resources for adoption planning should and can be made available to bring together children in other countries in need of permanent homes and the many families in this country eager to adopt them."

The chief weakness in proxy adoptions, the report points out, is the lack of any requirement of the two basic protections in adoption: (1) a social study of child and home by a licensed social agency, preferably prior to placement; and (2) a trial period of supervised residence of the child in the prospective adoptive home.

The investigators reviewed what information they could obtain on 74 families who adopted children by the proxy method between September 1957 and June 1958. In 29 of these they found information "clear enough to indicate that the adoption had not succeeded or that the stability of the placement was in question."

In these cases they found evidence of physical abuse and neglect; misunderstanding on the part of adoptive parents of their permanent legal responsibility for the child, as indicated by their giving the child away to another person; physical or mental disability on the part of the adoptive parents; serious physical problems on the part of the child about which the adoptive parents had not been informed; failure on the part of natural parents to understand that they were permanently relinquishing their rights; failure by the agents to followup good possibilities of adoption by blood relatives.

Pointing out that State laws are being ignored in most of these placements, the report states that children adopted by proxy have been brought to 38 States, 30 of which require such studies before a court can make an adoption final.

Listing a variety of types of organizations and individuals who act as agents in finding children, the report suggests that while most of them are acting out of a real concern for children, they do not proceed on the basis of modern knowledge of what children require. In some instances a profit motive seems to be involved. The difficulty with all of their efforts, it suggests, is that the emphasis is on finding children for parents rather than parents for children. In this way, it points out, "chance and only chance determines the kind of homes these children find."

The report, which was prepared by Laurin and Virginia Hyde, is being published by the Child Welfare League of America.

## *Against Polio*

Noting the high effectiveness of the present 3-injection schedule for vaccination against poliomyelitis with Salk vaccine, an advisory committee to the Public Health Service recently reported that routine fourth injections are not necessary. However, the committee agreed that exceptions might be made by individual physicians, if for example, a local outbreak of polio is beginning or a person is about to travel to a place where the polio incidence is high. It was agreed that if a fourth dose is to be administered, it need not be given sooner than a year after the 3-injection schedule is completed.

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A test group of 139 children who were inoculated against poliomyelitis with Salk vaccine in 1955 have been found to be still immune to the disease in 1958, according to a report made recently to the American Association of Immunologists. Pointing out that "serum antibodies" are created in the bodies of persons inoculated with Salk vaccine, the report states that 3 years after these children were inoculated they still had enough serum antibodies to provide immunity.

## *Community Action*

A concerted approach in working with families suffering from a multiplicity of problems recently grew out of a slum-clearance and redevelopment program in Pittsburgh. Under the auspices of the Allegheny County Health and Welfare Association, 14 cooperating social agencies are conducting an experimental program to help 100 such families who had been difficult to relocate to achieve acceptable ways of living. Included in their problems were truancy, delinquency, crime, promiscuity, poor health, mental illness, and dependency. The families had averaged 10 previous contacts each with health and welfare agencies.

Faced with the task of relocating these families, the Pittsburgh Housing Authority called on the Health and Welfare Association late in 1956 for help. As a result, a group of executives of agencies whose services seemed to be most needed formed an advisory committee on relocation.

The committee, still operating, suggests ways in which the agencies can pool their efforts to help the families achieve acceptable ways of living. It holds monthly meetings at each of which about five families are discussed. A plan of treatment is arrived at, with the agency that has had the most contact with the family, or that seems best equipped to treat it, accepting the main responsibility. If other agencies are working with the family they coordinate their work with the primary agency. All the agencies keep in contact with the housing authority, and make written reports to the advisory committee. The primary agency does not relinquish contact with the family without discussion with the committee.

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To help community leaders reduce tensions in racially changing neighborhoods, Philadelphia's Commission on Human Relations has developed a kit of materials that includes a handbook called "Your Home in a Changing Community"; a sample guide for meetings on the subject of changing neighborhoods; a sample letter inviting people to attend such a meeting; instructions concerning a filmstrip, "The House Across the Street"; and a fact sheet on the high cost of moving, addressed to persons thinking of leaving a changing community. By paying 15 cents mailing costs organizations may borrow kits for 10 days from the National Publicity Council for Health and Welfare Services, 257 Fourth Avenue, New York 10, New York.

## *Juvenile Delinquency*

A study of sociocultural factors in delinquency among boys under 18 in Los Angeles County, with emphasis on Mexican-Americans, is being completed by the Welfare Council of Los Angeles with a $12,000 grant from the Rosenberg Foundation of California.

In 1956 boys from Mexican-American families constituted 18 percent of the boys referred to the county probation department for delinquent acts. Noting a disproportion (persons of Mexican-American descent amounted to only about 6 percent of the population of the county) the council last year set out to discover whether Mexican-American boys and those of other ethnic groups—"Anglos," Negroes, and Japanese—showed differences in the patterns of their delinquent acts. The aim of the study is to isolate any combination of factors that seems to account for the presence or for the absence of such differences.

Questioning the adequacy of such explanations of high delinquency rates in specific ethnic groups as minority-group status, frustration due to discrimination against the group, and "high visibility," which leads to easy discovery of their actions, the council points to the fact that the Japanese in the county, who undergo the three disadvantages named, had a lower delinquency rate than any other ethnic group.

The general hypothesis examined in the study is: "Delinquent acts that come to the attention of the police (as distinguished from all acts that would be judged delinquent if the police knew about them) are not randomly distributed. Cultural factors associated with ethnic-group and social-class status contribute significantly to the risk of exposure to becoming a publicly identified delinquent."

Among the other hypotheses that the council is testing through analyzing the pattern of delinquent acts known in 1956 are:

That the frequency and type of delinquent acts vary within an ethnic group according to the social values and aspirations of socioeconomic classes.

That youngsters join gangs because they are denied status in respectable society.

That because of the closeness of Mexico to California, third-generation Mexican-American youths in Los Angeles are still affected by a conflict between cultures characteristic of other ethnic groups in the second generation.

## *Child Welfare*

As a step toward developing more adequate child-welfare and other welfare services, the North Dakota Public Welfare Board's division for children and youth is sponsoring a 4- to 6-month child-welfare training unit at Bismarck in cooperation with the Burleigh County Welfare Board. The purpose of the unit is to give college graduates a broad, general understanding of the public welfare program plus a limited experience, under supervision, in interviewing clients, recording cases, and using community resources; and thus to enable them to enter social-work jobs or graduate schools of social work better prepared to accept instruction and suprevision. Students are encouraged to consider entering a graduate school, and an effort is made to avoid offering instruction that would be repeated in such a school.

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A television course on modern child-welfare services, recently given by the University of Tennessee School of Social Work on a Knoxville station, outdrew the two other television courses given by the university, according to a survey made by a commercial research bureau, which estimated the average number of viewers of each of the programs presented by the station during a specified week.

The course, which carried no credit, was presented in half-hour sessions twice a week for 13 weeks. The instructor, an associate professor in the school of social work, discussed the needs of children in general and the kinds of problems faced by children and parents needing help. He described the characteristics of modern child-welfare services and the long-time experiences through which the profession of social work has arrived at today's methods of providing such services. The aim was to instill confidence in the viewers so as to help them make use of child-welfare services, refer others to agencies providing them, and work toward strengthening such services in their own communities.

## *Against Staphylococci*

The Public Health Service, the Children's Bureau, the American Medical Association, the American Hospital Association, and the American Academy of Pediatrics are among the groups urging hospitals, physicians, local health departments, and research workers to combat the dangers arising out of new strains of staphylococcus, which resist antibiotics and are killing many patients with low resistance, including premature and other newborn babies and their mothers.

In view of the increasing frequency of epidemics of staphylococcic infections among newborn babies, the American Academy of Pediatrics recently issued a report urging hospitals to adhere strictly to the principles of aseptic and antiseptic technique set forth in the 1957 revision of its publication, "Standards and Recommendations for Hospital Care of Newborn Infants," and setting forth a number of other recommendations. Among these is the establishment by each hospital of a committee on control of cross-infections, to be responsible for efforts to prevent, investigate, and control infections and to work with local, State, or Federal health agencies when necessary.

Since signs of a hospital-acquired staphylococcic infection may not develop for several days or weeks, each hospital is urged to make clear to all been anything more than a screening or screening out process? Miss Dunne's discussion of the positive use of group meetings of adoptive parents after adoption has been completed is certainly worthy of attention.

*Letitia DiVirgilio*
*Supervisor, Inter-Country Adoption Department, Boston Children's Service Association, Boston, Mass.*

### OHLIN: *A unique approach*

Dr. Ohlin's article presents a solution for training schools to the ever-present problem of how a new and progressive administraton handles members of the staff who are entrenched and resistant to change. (See "The Reduction of Role Conflict in Institutional Staff," by Lloyd E. Ohlin, CHILDREN, March–April, 1958.)

At first, some of these staff members leave voluntarily, being unwilling or believing themselves unable to change. Others are asked to leave. Those that remain and want to work with the administration are either won over to the new way of doing things or removed from positions where they can influence policy, with new staff members being placed in policy positions.

This is a perfectly logical administrative approach. It is particularly needed where role conflict breaks out between the old and new groups and even more urgently needed when the student body steps into the power vacuum created by pulling the staff apart.

What is somewhat unique in this reader's experince, is the use of the casework supervisors as policy makers in line authority positions with virtually complete control over discipline, administration, and evaluation of staff performance, at the same time remaining responsible for carrying out all of the treatment of the girls in the cottages. It is more usual to expect that administrative, disciplinary, and personnel matters, with all of their timetaking details, be divorced from the important and equally heavy treatment responsibilities. One would then replace the cottage staff "seniors" who are resistant to treatment concepts with those cottage staff members who are, or who can be, trained to be concerned with individual treatment, thus furnishing an added incentive for the staff to learn the new methods.

In time one develops a group of cottage staff members and their supervisors who do run a "quiet, orderly, but treatment-oriented cottage."

The alternative suggested in Dr. Ohlin's article appears to have accomplished the new administration's purpose. The social-work supervisors should certainly do a good training job with the cottage staff. Their being added to the "home life department" is a move that we would all endorse. We would, however, like to see more understanding of the experience, dedication, similarity of objectives, and trainability of most cottage staffs.

*Louis Jacobs*
*Superintendent, National Training School for Boys, Washington, D. C.*

### GURNEY: *Pertinence for others*

The approach described in Miss Gurney's article should prove successful in all work in regard to children with handicapping conditions whether the child is blind or mentally retarded, or whether he has cerebral palsy or a congenital amputation. (See "Parents of Children With Congenital Amputation," by Wilma Gurney, CHILDREN, May-June 1958.)

The basic point Miss Gurney makes is that helping a handicapped child is a family affair. The child's own attitudes toward the handicap and toward his use of services offered are largely determined by his family's attitude toward him, toward his handicap, and toward the program. These attitudes need to be fully understood. Parents and children need to be helped to deal constructively with their reactions of guilt, rebellion, overconcern, and the like before complicated medical therapy can be begun or expensive equipment can be provided.

Preparatory work thus would be geared to help parents: (1) understand their child's condition, the diagnosis and prognosis; (2) understand and accept their own feelings in relation to the child's handicap and learn to deal with them; (3) understand and accept their child's feelings; (4) differentiate between difficulties caused by the handicap and those caused by behavior that is incidental to lack of parental control; (5) see the child as a member of his family without discrimination against him or against other members of the family; and (6) make constructive use of services offered.

The children themselves can, as a rule, be most successfully helped by a parent who has clarified his own approach to the situation.

*Helen L. Beck*
*Chief Psychiatric Social Worker, Mental Retardation Unit, St. Christopher's Hospital for Children, Philadelphia, Pa.*

### BEGAB: *A stimulus for social workers*

Michael Begab's paper must be considered as a significant contribution to social-work literature in the field of mental deficiency, for by filling in many gaps it meets a long-felt need. (See "Child-Welfare Services for the Mentally Retarded," CHILDREN, May–June 1958.)

In recent years interest in the mentally deficient child has increased. This has been reflected in the professional literature in various professional disciplines, especially psychiatry, psychology, and education. The growth and increasing influence of parent organizations and the expansion of educational opportunities offered these children by the public school are two other indications of this phenomenon. However, the social-work profession as a whole has not kept pace with these developments. The average social worker has not acquired extensive experience with this problem and consequently his knowledge and understanding of mental deficiency has suffered.

While there are social workers who have been working actively and effectively with the problems associated with mental deficiency, their contributions have not been reflected in professional social-work literature except in piecemeal fashion. The major value of Mr. Begab's paper is its concise yet comprehensive, up-to-date presentation of the complex social and psychiatric problems with which a social worker must deal in his efforts to provide a service to the mentally deficient child and his family.

While the article does not add to the existing body of professional knowledge of those social workers whose job brings them in daily contact with mentally deficient children and their parents, obviously, this was not its intent. It is hoped that it will provide a stimulus for others to contribute to the professional social-work literature in this field.

*Alvin P. Sion*
*Supervising Psychiatric Social Worker Pacific State Hospital, Pomona, Calif.*

U. S. GOVERNMENT PRINTING OFFICE: 1958

## SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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PUBLIC ASSISTANCE UNDER THE SOCIAL SECURITY ACT; old-age assistance, aid to dependent children, aid to the blind, aid to the permanently and totally disabled. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance. 1957. 29 pp. 25 cents.

Describes the programs named in the subtitle and explains in general terms the responsibility of the Federal agency and the State governments under the public-assistance titles of the Social Security Act.

COST OF SERVICES TO CRIPPLED CHILDREN: a study of nine State programs. Department of Health, Education, and Welfare. Social Security Administration, Children's Bureau. CB Statistical Series No. 43. 1957. 27 pp. Single copies available from the Bureau without charge.

Results of a pilot study in regard to nearly 100,000 crippled children in nine States are set forth in this publication, which reports information from crippled children's agencies on direct expenditures for the care of individual children, classified by diagnosis and by type and volume of service. Also, for six of these agencies the report shows expenditures for direct services not explicitly related to the individual child, such as the annual salary of a staff physical therapist and expenditures for indirect services by medical and other personnel and for training.

HEALTH STATISTICS FROM THE U. S. NATIONAL HEALTH SURVEY. Preliminary reports on volume of physician visits and of dental care in the United States, July September 1957. Department of Health, Education, and Welfare, Public Health Service. PHS Publication No. 584—Series B1 and B2. 1958. Series B1, Physician Visits, 25 pp. 25 cents. Series B2, Dental Care, 22 pp. 25 cents.

These two reports present information based on interviews collected in about 9,000 households, including approximately 28,500 persons. For children under 5 the number of physician visits during July, August, and September 1957 came to an average of 4.8; 8 percent of these children had visited a dentist in the past year. For those 5–11 years of age the physician visits averaged 3.4, and 16 percent of the children of that age had visited a dentist. For persons in the age group 15–21 the average number of physician visits was 5; visits to a dentist had been made by 50 percent.

YOUTH GROUPS IN CONFLICT; a report of a conference. Mary E. Blake. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Pub. No. 365. 1958. 52 pp. 25 cents.

Reports a 3-day working conference focused on study of current practices in extending services to self-directed groups of hostile, antisocial youth. The sense of the Conference is reported by merging the ideas and concepts of the speakers with the contributions of the conferees around six major topics: Youth Subcultures in American Society; the Nature of the Groups; Objectives of the Service; the Nature of the Service; The Worker; and Administration of the Service.

TRANSITION FROM SCHOOL TO WORK. Department of Health, Education, and Welfare, Office of Education. 1957. 12 pp. 10 cents.

This folder, developed by a subcommittee of the Interdepartmental Committee of Children and Youth, is addressed to teachers, counselors, parents, and all others who are in a position to help high-school graduates in occupational choice, preparation for work, placement in a job, or adjustment and growth on the job.

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Child Beneficiaries of OASI

Health for School Children

Limits in Child Rearing

Child-Welfare Challenges

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ABSORBED IN LEARNING, this boy is one of 39,700,000 children who will attend school in the United States during the current school term. What they learn will depend on many factors in addition to their own intellectual abilities, some of which were listed in a workshop held by the Interdepartmental Committee on Children and Youth last June (see page 198). An important factor is health. Ways of improving the health of children of school age are suggested on page 169.

Neota Larson's career has included service in three bureaus of the Social Security Administration: Old-Age and Survivors Insurance, where she was formerly chief of the program-planning branch of the division of program analysis; Public Assistance, where she was once a social-service consultant; and the Children's Bureau, where, before going to OASI, she was assistant to the chief. Trained in social work at the University of Minnesota, she began her professional work in a county welfare department in Maryland.

Georgia B. Perkins has been with the Children's Bureau since 1952, spending a year as medical director of Regions I and II, with headquarters in New York, before going to the Denver regional office. A native of Denver, she took her medical degree at the University of Colorado, where she is now assistant professor in the School of Medicine's Department of Preventive Medicine, and a public-health degree at Johns Hopkins. Privately, she is Mrs. Herbert Reno, II.

In addition to being a clinic director Calvin F. Settlage is associate professor of psychiatry at Temple University's School of Medicine. Before joining the staff of the St. Christopher's Hospital Psychiatric Clinic in 1955, he was for 4 years staff psychiatrist and psychoanalytic psychotherapist at the Devereux Schools, a private institution for the mentally retarded in Devon, Pa. He was previously child psychiatrist and chief of psychotherapy at the Governor Bacon Health Center, Delaware City, Del.

Because he regarded the Israeli collective communities (kibbutzim) as natural laboratories for studying the effects of child-rearing practices, Albert I. Rabin headed directly for Israel when his sabbatical leave from the University of Michigan came due in 1955. Since his return he has reported on his findings bit by bit in various professional journals, and here presents an overall view of his comparisons. Dr. Rabin was at one time chief psychologist at New Hampshire's State mental hospital and mental-hygiene clinics.

Maurice O. Hunt writes out of a broad experience in welfare administration, including service as assistant director of the American Public Welfare Association, administrator of the Indiana State Department of Public Welfare, and executive of a council of social agencies. He has also been a staff member of a State training school for delinquents, a child-welfare consultant in a State welfare department, and a child-welfare specialist with UNRRA in Greece. He received his social-work training from Indiana University.

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*Coordinated planning, locally and nationally,*
*is required for meeting problems of . . .*

# CHILDREN RECEIVING OASI BENEFITS

NEOTA LARSON

*Chief, Welfare Branch, Division of Claims Policy, Bureau of Old-Age and Survivors Insurance, Department of Health, Education, and Welfare*

THE old-age and survivors insurance program is one of family security. Today about 1½ million children under age 18 and 325,000 mothers are receiving monthly benefits. Typically, the home of a child beneficiary is one that is broken by the death of a parent. Only some 180,000 of these beneficiaries are minor children of aged retired workers.

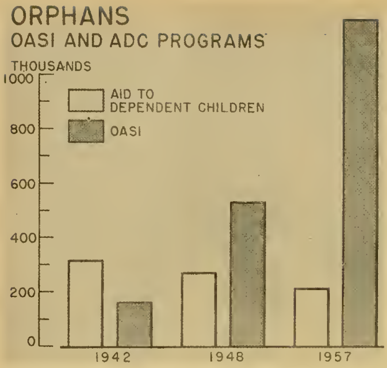
Under the provisions of the Social Security Act, the Bureau of Old-Age and Survivors Insurance selects the person who will receive the child's benefit, with responsibility, in a trust capacity, to use the benefit funds in the child's interest. Since 1940, when benefits were first paid to mothers and children, the Bureau has accepted responsibility for administering this provision in such a way as to strengthen, wherever possible, the ability of the family to plan for itself.

It is a matter of great importance in the child's life who is selected as his representative payee. Whoever receives the money determines what use will be made of it and usually the kind of care the child receives.

The objective is to put the control of the funds into the hands of the person who is responsibly planning for the child. Usually this is the mother. Almost always the mother is selected to receive and manage the benefit funds if the child is living with her; she is also selected if the child is living elsewhere if she continues to be the person planning for him. Some mothers are not capable of assuming this responsibility or if the child is not living with them may not want to handle the child's benefit money. In such instances, another person may be selected; but the mother is never passed over lightly. If someone else is selected, this is usually the person with whom the child is living, but it may be some other person who has responsibility for him, or a social agency active in planning for him. A legal guardian whose interest is purely fiscal—the receiving and accounting for money—is low in the order of preferred payees.

Over 90 percent of child beneficiaries have a parent, usually their mother, receiving their monthly checks. Other relatives, legal guardians, foster parents, institutional officials, are representative payees for the remaining children.

OASI benefits are only a partial replacement of earnings lost because of the death or retirement of the worker—the earnings upon which the children were dependent for their support when the worker was living, or before he retired. It is assumed, therefore, that the money will largely be used to meet the cost of day-by-day living. The mother usually puts her benefit money and the children's together, using the total to meet family needs. No questions are raised about this commingling of funds unless there is evidence that the mother is grossly neglecting her children, or that she is di-



The effects of broadened coverage and the maturing of old-age and survivors insurance are shown in a sharp rise in the number of orphans (children with one or both parents dead) receiving benefits. Simultaneously the number of orphans receiving aid to dependent children has gradually declined.

verting the children's benefits to purposes other than their care.

The Bureau has long been aware of the need of many of these beneficiary children for health and welfare services. Some persons have suggested the development of such services within the old-age and survivors insurance program. The Bureau came to the conclusion early, however, that the sounder approach was to put families in need of help in touch with established community programs so that they will share in the basic protections provided for all children, some of which derive from State law. Local district offices have responsibility for knowing what resources the community has and when a person expresses a need for service of referring him to the appropriate State or local agency. When there is evidence of gross neglect of a child receiving benefits, when there is no person responsibly planning for him, or when there is a conflict between potential payees of such a nature that the child's welfare may be materially affected by the choice made, the OASI district office takes the initiative in asking a social agency, usually the public welfare department, to provide needed services, and to recommend a payee for the child's benefit check.

Formal arrangements have been worked out by the Bureau of Old-Age and Survivors Insurance through the regional representatives of the Children's Bureau with all State welfare departments for this kind of advice and help. This is an example of how two programs can and do work together in the interests of the welfare of children, each taking action within its own basic responsibility.

Some communities have not established the services children need. In others where a great variety of services are available, there may be gaps in the programs of service. The Bureau of Old-Age and Survivors Insurance has, therefore, encouraged local district office staff to participate in overall community planning for children and adults. Recently the Bureau took a further step toward a more effective service to its beneficiaries with the creation of a Welfare Branch in the Division of Claims Policy.

The Welfare Branch has two responsibilities. One is the development of policies governing the selection of the person who will act as the representative payee for children and for adults incapable of managing their own benefit funds. The effectiveness of these policies in serving the best interest of these beneficiaries is studied with resultant modification in policy as indicated. The other responsibility is to establish guidelines for OASI district office staff for participating in overall planning for needed community health and welfare services.

Representatives of the Welfare Branch work directly with public and voluntary national organizations which have as their objective development of services for both children and adults. This development is within the Bureau's original policy position that it will not develop a special service program for its beneficiaries, but will keep itself aware of the many interrelated problems which children and adults may have and make their needs known to the agencies and groups responsible for planning services for them.

### *The Protection Provided*

Nine out of 10 of the young mothers and children in the country now have survivorship protection under the OASI program, that is, they would be able to draw monthly benefits today if the father were to die. In order to be insured under the program for survivorship purposes, the father must have worked in covered employment for roughly half the time within the 3 years preceding his death. Benefits are also paid to children of aged, retired workers, although these are only a small part of the total number of children receiving monthly checks.

The child's monthly check is a fixed proportion of the benefit amount due the parent whose earnings entitle the child to a benefit. This proportion is, in effect, three-fourths for the first child and one-half for each succeeding child. The total family benefit may not exceed 80 percent of the worker's average monthly earnings in covered employment or $200, whichever is the smaller amount. The average monthly benefit for a child is now $41; the average benefit for a mother is $48.90. The highest benefit that may be paid a mother or single child beneficiary is $81.40.

About 150,000 of the children now receiving benefits are of preschool age. Some 450,000 fall in the age group of 6 to 11 years. Over 700,000 are 12 to 18. Entitlement to benefits continues until age 18 unless the child marries, or he is adopted by someone other than a grandparent, an uncle or aunt, or a stepparent. Most children will have finished high school by the time they reach 18, or will have nearly completed their high-school work.

If a beneficiary goes to work and earns more than $1,200 during the year, he may have one or more of his monthly benefits suspended, depending on the amount of his earnings. If his earnings are more than $2,080 during the year he will receive no benefits for that year, except that he will get benefits for any months in which he earns less than $80 and is not rendering substantial services in self-employment. Teen-agers may, therefore, do a substantial amount of work during the summertime and after school or on week ends during the school year without loss of benefits.

### *The Usual Situation*

Most beneficiary children are living with their mothers. The mother may use the benefit money for current maintenance, which is broadly defined to include whatever in her judgment is needed—food, clothing, music lessons, roller skates, camping, or whatever other expenses she thinks appropriate—or she may conserve the money for some special purpose. Perhaps most mothers do a little of both in the same manner as families with both parents present will meet current needs and also look ahead to the future. A mother, or any other representative payee, may be required to account for the use of funds.

Since benefits are only a partial replacement of the earnings lost by reason of the death or retirement of the worker, most of these families do not have as much money coming in as they did when the father was working full time. It is very likely, therefore, that more of these mothers work than would be true of the population as a whole. Census data show that about 40 percent of widows, married women with the husband absent, and divorced women who have children under 18 are working outside the home as compared to 20 percent for mothers whose husbands are in the household. Where all the children are of school age, from 65 to 75 percent of the women who are heads of households are working.

We do not know the exact proportion of beneficiary mothers who work. We do know that 70,000 mothers had their benefits suspended for the month of June 1957 because they were earning at a rate of over $1,200 a year. Many other mothers may be doing seasonal or part-time work but making less than $1,200 a year.

The need of beneficiary mothers for community services to help in making satisfactory arrangements for their children during working hours may be greater than that of other mothers where the fathers are present to help in planning. A beneficiary mother may also have greater need for special counseling services to help her in arriving at a decision as to whether, in the light of her children's needs, her health, and whatever other responsibilities she may have, she can carry the dual role of mother and worker without adverse effects on herself or her children. The beneficiary mother, like other mothers, needs to balance the advantages to her children of a more adequate income against the advantages of more time spent with them while they are growing up and more time available for homemaking. The decision to stay home may be a harder one for her to make because the economic pressures are greater.

A beneficiary mother has another reason for working while her children are growing up. She needs to plan ahead for the years when there will be no monthly benefit checks coming in, the years between the time when the youngest child reaches age 18 and the time she reaches her 62d birthday. If she has no other income to rely on and is not to be dependent upon her children or other relatives during this period, she has to maintain, and increase if possible, her ability to earn a living. Long periods away from work may be a handicap to her in getting a suitable job when she must be self-supporting.

For some families OASI benefits, when taken together with whatever other resources they have, are inadequate to meet their basic needs. A little over 5 percent of all child beneficiaries are now receiving supplementary aid-to-dependent-children payments under the federally aided State public-assistance programs. However, the OASI program has been effective in reducing significantly the number of children in need of public assistance because of the death of a parent. In 1942, 36 percent of the aid-to-dependent-children caseload was made up of children who had lost one or both parents by death. This had fallen to 10 percent by 1957. It is doubtful whether an overlap in these programs can ever be completely eliminated, since there will always be some families with needs which OASI benefits alone cannot meet and where it is impossible, or unwise from the standpoint of the welfare of the children, for the mother to go to work to make up the deficit.

### *Children With Other Families*

Some child beneficiaries are living with relatives other than a parent when the application for benefits is made, and some may go to live with relatives at a later time. If the mother is not active in the planning for the child, the relative with whom he is living is ordinarily selected to receive the benefit check. Experience has shown that a fair proportion of these arrangements are not permanent ones, that some "other relatives" are not able, and some not willing, to assume the same kind of responsibility for these children as they would for their own.

For example, the Bureau had assumed early in the program that a child living with his grandparents was assured of a more or less permanent home, likely to last until he reached age 18. Recent studies have shown, however, that many grandparent-grandchild homes do not continue in this way. This may be due to a number of reasons. The grandparents may be less able to cope with the problems of a small child or an adolescent, or they may have illness or other problems which affect their ability to continue to care for their grandchildren.

In order to have emotional security, a child needs a stable environment; he needs to know that there is someone he can depend on not only for today but also for the tomorrows that stretch ahead through the years of his growing up. A permanent home for every child is one of the goals of child-welfare services. Yet some beneficiary children seem to be shunted from one place to another, from relative to relative, or parent to relative.

The Bureau finds out about these changes because one of the requirements of the person receiving the child's check is that he report a change in custody. When such a report is received, the district office follows up to see if a new payee should be selected. We would like to be able to refer some of these children for whom there has been a succession of payees to a community agency which could help the relatives to develop a more stable plan. We find, however, that children who are moved around among relatives are often in the "no-man's land" of community services.

We do not know how large this problem is in absolute numbers. We do know that district offices all over the country are troubled at some time or another by this kind of problem.

Other child beneficiaries are living with persons who are unrelated to them. In order to support the basic protections society has set up to safeguard the welfare of children in foster care, before deciding whether a foster parent can be selected as payee of the child's benefit check, the Bureau finds out whether the home meets the State licensing requirements. If the home does not meet State standards, the Bureau looks to the appropriate community agency to evaluate the plan for the child's care, to make changes if needed, and to recommend the person who can be relied on to use the benefit money in his best interest. In instances where a child has been placed in a foster-family home by a public or voluntary agency, the agency's recommendation is followed as to whether the foster parent or the agency shall be the payee.

### *Children in Institutions*

The selection of a representative payee and the use of benefits for a child who is in an institution brings into focus other factors, including the policies and practices of the institutions themselves. An official of a child-caring institution may receive the child's benefit check as his representative payee if there is no responsible person outside the institution to act in this capacity, providing the institution meets State standards and operates a child-placement service, or has arrangements with some community agency for child-placement services. Where there are no child-placement facilities available to the institution, the State welfare department is notified of the payment.

By these requirements, the Bureau supports a basic child-welfare principle, that a child not be continued indefinitely in institutional care if another plan would be better for him. Where a parent or other person outside the institution or a social agency is selected to receive the check, the payee needs to discuss the use of the child's benefit funds with the institution's representative, taking into account not only the cost of the care provided by the institution, but also any other needs the child may have, as well as the possibility of conserving some of the funds to carry out a plan for his future.

There is a wide variation among child-caring institutions in theories of how a child's benefit should be used. Since the top benefit a child may receive under present law is $81.40 a month, and the average for all children is $41, a benefit often does not equal the cost of the care the institution provides the child. Where this is true, some institutions, on the theory that priority should be given to reimbursing them for the cost of care, routinely use the benefit funds for this purpose when someone on the institutional staff is selected as payee. They point out that if the child were living with his mother she, too, might have to use the total amount of the benefit funds to meet the cost of food, clothing, and shelter, and be able to afford very few other things for him or to save any of the money for his future needs.

However, there may actually be more need for an institution to conserve part of a child's funds for future use than there would be for a parent. The parent with marginal economic resources who cannot save even small amounts is usually able to help the child in his transition from school to work by providing him with the continuing resource of a home to help him over the rough spots—a place to live, with the mother doing many practical things for him during the period when he is getting started.

Some institutions have questioned the advisability of a child's knowing that he is receiving a benefit, on the grounds that this knowledge might set him apart from the other children in the institution who do not have this kind of resource. Some ask too whether it is wise for one child in the institution to have needs considered for him which cannot be considered for all the children.

Since the institution is the child's principal creditor, with fixed and continuing costs to meet, as well as the principal planner for the child, a conflict of interest may be created when the institution is selected as payee. Some institutions, nevertheless, use the benefits flexibly to meet the child's changing needs; others apparently do not. One child-caring institution, for example, uses the benefit funds when the child is small primarily as reimbursement for cost of care, but as he approaches his teens plans with him for the accumulation of some of the money to carry out his future plans. Certainly it would seem essential for a child, when he is old enough, to know about the benefit being paid to the institution and the use to which it is being put.

The many perplexing problems in this area need continuing study not only by the Bureau of Old-Age and Survivors Insurance but also by institutional personnel, with joint consideration as to their best solution.

### *The Meaning for Children*

OASI benefits have reduced the possibility of the home being broken up for economic reasons alone. They have also reduced the number of children needing help under the public-assistance program because of the death of a parent. The value of the benefit check as the cornerstone of the family's economic planning is clear. The security provided by the certainty of its coming frees the family to move into the pattern of living it sets up for itself.

Interviews have recently been completed for a representative sample of child-beneficiary families which will give more information than is now available about their income from all sources and the expenditures they incur—how they live and how they manage. The data obtained will be used to evaluate benefit levels and to give clues to other problems these families have. They will be published for the information of all persons interested in formulating their own views about the adequacy with which the program meets the economic needs of children.

Other provisions of the program also need study; for example, the provisions of the law which define a child for benefit purposes. Benefits are now payable to a legitimate or adopted child of the worker, under certain conditions to a stepchild, and under limited circumstances to an illegitimate child. The Social Security Act provided that the law governing the "devolution of personal property" in the State where the worker was living at the time of his death, or in the State of his permanent residence at the time of his application for retirement benefits, be used in determining whether a child meets the legitimacy requirement. In other words, the test is whether the child can inherit from the parent in the absence of a will.

We are aware of certain problems which flow from this provision. An illegitimate child may have the right of inheritance under some State laws, but in exactly the same family circumstances have no inheritance rights in another State. Not long ago, a case came to the Bureau's attention of a father who had moved his family from one State to another a few months before his death. Under the laws of the

State where this man had lived most of his life and had most of his OASI coverage his five children would have been eligible for benefits at his death, based on their right to inherit from him even though it turned out there was not a valid marriage. In the State in which he died, however, his children had no such inheritance rights. As a result, they had to be denied survivor's benefits.

In many such cases where benefits have had to be denied, both parents have been present and caring for their children for many years. There has been a loss of earnings against which the program ordinarily protects children, but benefits may not be paid. Considerable study has been given to the question of whether the program could include these children for benefit purposes. The Social Security Act would need to be amended to accomplish this purpose.

More studies are being planned to find out how well the policies governing the selection of the person to receive the child's benefit as his representative payee actually serve children. Beginnings have been made in some States on joint studies with other agencies of the effectiveness of the selection process. For example, the New York State Welfare Department, working cooperatively with the regional staff of the Children's Bureau and of the Bureau of Old-Age and Survivors Insurance, has recently completed a study of a representative sample of children for whom the New York local welfare departments are payees of the benefit checks.

This study showed that the local public welfare departments are planning responsibly for these children, working with parents and other relatives as well as with foster parents and institutions providing care. The benefits are helping to support the children while at the same time, in some instances, some of the funds are saved to carry out plans for the children's future.

Studies are also needed to determine how well benefits serve children in less protected situations, for example, children living with unrelated persons not under the care of a social agency.

### *Program Interrelations*

In society's programs for children, a separation of services is necessary for both administrative and program purposes. However, if these separations result in each program focusing narrowly on its own particular job, the individual child may be caught between conflicting approaches. If those responsible for each program consider only the gaps in their own services, other equally essential needs may never get the consideration they ought to have. As we have seen, the effectiveness of the OASI program is in many ways dependent on essential health, welfare, and other services being available in the community where beneficiaries live, to which the program and families can turn for help when it is needed. Similarly, the provisions of the OASI program and the way in which it is administered vitally affects other programs.

There needs to be an agreed upon set of principles underlying all programs serving children. If it is agreed, for example, that the first obligation of all programs is to strengthen the family, a higher priority may have to be given in the future than has been in the past to the development of community services such as homemaker services, to avoid wherever possible the necessity of placing children outside their homes when a parent is ill or otherwise not equal to the day-by-day duties of running the household. Since care elsewhere is usually more costly than care in a child's own home, benefits are likely to be more adequate to meet the child's needs if such services are available. Once the goals have been agreed upon, the Bureau of Old-Age and Survivors Insurance, as well as other programs serving children, will be in position to reexamine its policies and practice to determine how well they provide the safeguards and protections which children need.

**. . . . you can't bring health and happiness to a million children by signing a paper or waving a wand. It has to be done child by child.**

*Danny Kaye in the preface to* Half the World's Children, *by S. M. Keeny.*

*The purposes of health evaluations change in order of priority with the child's age in sound planning for . . .*

# IMPROVING THE HEALTH OF CHILDREN OF SCHOOL AGE

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EDMUND FULLER, the novelist and critic, recently wrote in commenting on the writing of novels about man's physical or mental abnormalities: "Truly to understand a man who is sick you must understand a man who is well . . . . Yet I do not suggest that the true knowledge of man is an easy healing of ills . . . ."[1]

In considering the health of our school-age children in the past, I think we have emphasized understanding the sick rather than the well child, and, having understood, have considered this understanding as a goal in itself— "an easy healing of ills." We have not always used our knowledge of the child's illness or wellness to the fullest advantage of the child himself by regarding the process of finding out his state of health only as the beginning of our efforts rather than as the end. We have not placed as much emphasis on doing something about his defects as we have on finding them. We have too often not emphasized keeping him well as much as finding out how well he is.

To go back one step further: Do we really know whether or not the child is well?

Undoubtedly, we have taken great pains to discover whether or not his heart presents any unusual sounds; whether or not he sees as well as other children; whether or not he hears as well as he should; whether or not he weighs as much as we think he ought to; and how many carious teeth he has. These are tremendously important factors in the health of the school-age child. We need to know about them in order to help him develop normally and in order to help him learn under the best possible conditions for him.

But do we know enough about how this child reacts to stress, how he responds to authority, what kinds of support or problems he experiences at home? Do we know what other people—other doctors, other dentists, his teacher, his parents, the social worker, his friends—are telling him about his health or what he should do about it? Do we know anything about what he thinks about what we are doing to or with or for him? Have we taken time to find out what he himself understands about the fact that he has more holes in his teeth than we think he should, or that he seems to be growing faster or slower than he did last year?

Knowing about these things are all part of understanding the child who is well. It is commonly accepted that any one stage of the child's development is modified by the preceding stages. After all, the school-age child did not suddenly evolve out of thin air in time to go to school. He may be the same child who in earlier years had allergies to wheat which caused his mother no end of anxiety about his eating habits; now he reacts to stress by not eating and so is unusually thin and "too tired" in school.

We can predict some of the problems the child may have along the way from one stage to another

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**Based on a paper presented at the 1958 meeting of the Idaho Public Health Association.**

if we can only know about the ones he has already had. Therefore, one essential in improving the health of the school-age child is to learn as much about that child as possible and to use the information which other people working with the child have already gathered. The child's private physician knows a great deal about him and his problems; if the child has gone to a well-baby clinic or the family has had help from a social agency, these agencies may also have recorded observations pertinent to an evaluation of his current state of health.

Knowing as much about the child as possible also includes considering him not all by himself but as a part of his family, a child with or without both parents, with sisters or brothers; a part of his class of 30 or 40 or 50 in school where he stands 1st or 50th in arithmetic; a part of the social class and culture where a great deal or very little is expected of his scholastic performance. These considerations frequently require us as professional people to have a tremendous amount of tolerance, understanding, and willingness to accept for a child values which may be those other than our own.

A second essential of a well-rounded evaluation is consciousness of continuity, for the continuity is there whether we recognize it or not. No one physical examination, no one conference with a teacher about the child's progress in school, no one visit to the child's home will give us the whole picture. Neither will one lecture about his sleeping habits modify the sleeping patterns he has developed in the years preceding the lecture, nor will *talking* about a safe environment nullify the poorly lighted stairway he uses at school.

The status of the school-age child's health is greatly dependent on his health prior to the time he entered school. Unless we know about that previous period, we really do not know the child and we will have great difficulty in improving his health. Further, what we *can* do or should *try* to do to improve his health greatly depends on how much (or how little) has already been done in this respect before he entered school, how much is being done for him by others now, and what services his family can obtain or what we have to offer him during his future years in school.

In order to achieve this continuity and balance in efforts to improve the school-age child's health, it is appropriate to review the primary *reasons* for periodic school health evaluations of the child. Such a review will provide a perspective from which to determine not only how valid the evaluations themselves are, but also whether or not what we do with the results are the most complete, effective, and appropriate ways for improving the child's health.

### *Purposes of Evaluation*

There seem to me to be four basic reasons for evaluating a child's health regardless of whether this is done every 3 or 4 years or daily, and whether the child is an infant, a preschooler, of elementary-school age, or an adolescent. The following enumeration of them is not intended to be in any order of importance because I feel that the purposes take on different priorities depending on the age of the child. These purposes are:

1. To prevent abnormalities from developing in the growing child and thereby to foster the utilization of his full capacities. The abnormalities and capacities which must be considered in growth, development, and the effects of illness are not only physical but also emotional, social, and intellectual.

2. To determine defects which can be corrected or which may require modification of the child's living and learning patterns.

3. To evaluate the child's potentials in relation not only to his previous development but also to children similar to himself in physical, emotional, social, and intellectual development.

4. To educate the child in maintaining an optimum state of health, in preventing illness, in the need for and ways of correcting abnormalities and in ways of adjusting to illness, both acute and chronic. Actually, regardless of what we do for a child, we are educating him—whether for good or ill, whether we want to or not.

### *Priorities*

Having set forth what I believe to be the basic purposes of making a health evaluation of a child, I will now present what I think are the priorities among these purposes at the child's different age levels. A look at such priorities makes possible a better determination of the appropriateness of our emphases on various aspects of the evaluations, the programs developed, and the means used to carry them out.

***In infancy,*** the period between birth and about 2 years of age, these priorities would seem to be in the order in which I have already presented the purposes of evaluations, that is: (1) to prevent abnormalities and to foster the child's full capacities; (2) to determine defects which are correctable or which require modification of the child's living and learning patterns; (3) to evaluate the child's potentials in relation to his previous development and to similar children; and (4) to educate the child, for even a 2-year-old will remember his experiences with the dentist or the doctor and has begun to learn habits of various kinds. However, the health education in respect to a child at this age is primarily oriented to the parent. Consequently, counseling of parents is especially important.

***For the preschooler,*** the child between 2 and 6, I regard the prevention of abnormalities and the fostering of the child's full capacities still to be the first priority. However, I see as second in importance the evaluation of the child's potentials in relation to his previous development and to similar children, for this period brings an opportunity to determine more specifically what the child's capacities are. I see as the third priority the determination of the child's defects or abnormalities, for the majority of defects will have begun to show up by this time, especially if the child has had adequate well-child evaluations during his infancy. This still leaves as the number 4 priority health education of the child. At this stage the interpretation of the evaluation is still largely parent-oriented, and most of the effectiveness of health education depends on how much the capacities and understanding of the parents have been developed by persons working with them.

***For the child of elementary-school age,*** from 6 to about 12, the first priority still seems to me to be the prevention of physical, social, emotional, and intellectual abnormalities and the fostering of full capacities. As with the preschool child, the second priority is to evaluate the child's potentials. However, the third priority should be to educate the child in the maintenance of his own health, in the prevention of illness, in the importance of correcting abnormalities, and in ways of adjusting to illness. This demotes the determination of defects to fourth priority. The chances are that by now serious defects, unless newly developed, have already been recognized. The problem is not so much identification of defect as determination of why a correctable defect has not been corrected. This order of priority is based on the assumption that the child has received appropriate medical attention in previous years.

When we interpret the evaluation of a child in this age period, we are in a "transitional" stage between orientation toward the parents and orientation toward the child: both must be brought into the picture together. Counseling the child is as important as counseling the parents.

If the child is handicapped in any way, beginning modifications of his curriculum or of the ways in which he is taught or of subject emphasis is especially important at this stage; it is estimated that 10 percent of children require such special education,[2] but many more undoubtedly require at least temporary special attention.

In placing the determination of defect and modification of the child's living and learning patterns in last place for this age group, I do not mean to belittle the importance of detecting newly developed defects. For in a child in this age group we may discover for the first time defective vision, hearing loss, rheumatic fever, gingivitis and new dental caries, or the symptoms of withdrawal or aggression which may be early signs of serious maladjustment. But if the discovery of these defects is the only purpose for which we evaluate a school-age child—and it all too often is—then, I think we have not fulfilled our total obligation to him nor have we utilized the characteristics of the age period to their fullest potential. Of course, if the child has not received appropriate evaluations in previous years, or if we have not established the methods of communication to give us information about them, then discovery of defects may have to take a first-priority position. But *if these are the reasons, let us recognize them as such, try to correct them in the future, and not continue to make the same mistake just because it has become tradition to do so.*

***For adolescents,*** young persons between 12 and 21, the first priority still is prevention of abnormalities and the encouragement of the utilization of full capacities. At this stage, however, the second priority becomes health education because now the growing person not only is ready but can be made willing to take responsibility on his own for his state of health. The third priority for this age period is to evaluate the young person's potentials; and the fourth priority is to identify his defects.

Many persons concerned with child health may disagree with the foregoing order of priorities of purposes for evaluating the well child at various age levels. I myself am not completely convinced that health education should not be one of the top priorities in any evaluation. However, since I believe that one purpose in providing health evaluations is to define who is or should be responsible not only for seeing that they are obtained but also for how they are carried out, I have placed prevention of abnormalities and the fostering of the child's full capacities as first priority for all four age groups.

During the infant and preschool-age periods, the health education provided to the child must of necessity be of a lower priority because of the child's dependence on the education, understanding, and habits of his parents. On the other hand, the emphasis on health education becomes of much greater importance in the adolescent. When periodic evaluations in elementary school age children and adolescents are conducted primarily in order to identify defects, we are emphasizing that which we have earlier neglected.

I do not mean to imply that the determination of defects beyond the age of 6 is not important, but only to say that this should not be the chief emphasis of such evaluations. With other emphases, day-to-day evaluations can be as important as periodic examinations.

When we consider the purposes of evaluations, whether they are periodic physical or psychological examinations or day-to-day observations of the child's behavior, the program and procedures seem to evolve automatically. If professional personnel or finances are limited, as they usually are, determination of priorities in purpose helps to achieve more efficient utilization of the people and the money available.

### *Content of Evaluation*

The priorities themselves suggest the content of health evaluations for the various age groups.

*For the period of infancy* some of the elements of a good well-child evaluation include: immunization against illnesses which are particularly severe at this age or potentially handicapping such as pertussis and poliomyelitis; instructions to the mother as to the child's diet, the appropriate way to introduce new foods and the need for cleanliness; helping the mother to understand the origin of temper tantrums and periods of negativism and fear.

A careful physical examination at this time will identify, where present, congenital dislocation of the hip; congenital heart abnormalities; phimosis; possible mental retardation; abnormal responses to people. Apparent normality or possibilities of abnormalities in the child's rate of development and growth, social responses, and intellectual capacities can be observed.

While health education in this period is directed primarily toward the mother, the child himself is beginning to learn the use of the toilet, the meaning of cleanliness, and ways in which to adjust to illness and to gain attention.

***For the preschooler*** the prevention of accidents is probably the most important aspect of health care. This requires a combination of education of both the mother and the child. Emphasis on the maintenance of immunity levels, often neglected in this period, should be continued. Another highly important preventive measure is the avoidance of unnecessary extraction of teeth. Positive identification of exceptional intellectual capacities or of mental retardation is more possible at this time than at an earlier age, and procedures for preventing personality distortion and for permitting full development of the capacities in the exceptional child can be begun.

The time to prepare a child socially, emotionally, and physically for school is when he is still of preschool age—not after he arrives there. It is at this age that visual defects, speech defects, hearing losses, and dental abnormalities are most often overlooked because they are not sought. At this period too, some congenital abnormalities may become evident for the first time, such as some cardiac defects, renal abnormalities, certain metabolic disturbances and endocrine disorders, cerebral palsy, and epilepsy.

In this period many children with cerebral palsy or with impaired hearing can benefit greatly by special education. Since this is the time when the child learns either to take illness in stride or to utilize it for gains he is not otherwise able to make, he can now best be educated in adjusting to illnesses appropriately. He can also be taught not to fear the dentist or the doctor, but to look upon them as helpful friends.

The early school-age period may be the first opportunity for comparing the individual child with other children of his age. Since this is also the period when the child may for the first time face a competitive situation with other children, he may need help in adjusting to his own interests, talents, and intellectual potentials. In this period too, the child often exhibits his emotional "weak links" because he is exposed to an entirely different environment than he was used to at home. Therefore, it is now that efforts can best be directed toward the child's health education not only by setting examples but also by providing opportunities for healthful living. Alertness at this time to early signs of antisocial behavior may prevent later delinquency.

If the child's known physical defects or handicapping conditions have not been corrected by the time he reaches school, efforts to help him must be directed not toward their repeated identification but toward preventing additional defects and determining the reasons why the existing ones have not been corrected. We can then concentrate on correcting the *reasons* for negligence and thereby obtain the correction.

Nurses, teachers, and social workers, with their limited time, may welcome medical and dental assistance in determining priorities for defects in school-age children requiring intensive followup. Medical attention should also concentrate on discovering the newly developed cases of rheumatic fever, nephritis, nutritional anemia, and visual and hearing defects. Periodic reevaluation of handicapped children who have been placed in special classes is essential.

***The adolescent period*** is also the preadult period and the preparental period. It therefore presents us with the best opportunity we will probably ever have to concentrate on the child's health education not only for his own sake but also for his future children. Perhaps the greatest service we can do for an adolescent is to help him to appreciate his individuality while supporting and understanding his desire to be just like all his friends. To do this well we must know how he as an individual compares with his friends.

In dealing with this period we need to be especially alert to ways of preventing social and emotional abnormalities. Positive identification of already developed antisocial behavior and abnormal emotional responses is now easier. Moreover, many adolescents will give us the chance to identify potential abnormalities in social and emotional adjustment if we only take the time to listen to what they have to say.

Since adolescence is a stage of very rapid physical growth, the maintenance of good nutrition is now as important as it was during the child's first year.

Adolescence is a bit late for reidentifying defects which the child has had all along. Therefore the correction of known defects is probably the more productive use of time. However, it is now especially important to give the young person support, guidance, and counseling in learning to live with the defects he has, however minor we may think they are.

Some of the adolescent's physical problems are as characteristic of this age period as the problems of colic and teething are of infancy. Acne is frequent and, even in what adults consider a "mild" form, is distressing to the adolescent. Dysmenorrhea, obesity, chronic fatigue, epiphysitis, hyperthyroidism are some of the problems which most often first appear during adolescence. These problems, being especially distressing to the young person, often motivate him to seek medical care. The adolescent deserves to have *any* of them given as much attention as would be given to the detection of a hearing loss or congenital heart disease. This is true not only because of the defect itself, but also because the adolescent may be using this as an "excuse" for seeking out the doctor or the nurse in order to be able to get help for some of the anxieties he is experiencing.

If he decides that his presenting problem has been given the amount of attention comparable to the distress it causes him and that the person to whom he has gone is truly interested in him, he will very likely decide to unburden some of his emotional distress.

Because this is a period when reactivation of tuberculosis and rheumatic fever may occur and when diabetes and severe anemia may begin, it is important to be on the alert for signs of these illnesses and to use appropriate laboratory procedures for positive identification.

## *Toward Permanent Improvement*

We are frequently selfish in our approach to the evaluation of children of school age. Often we seem more concerned with the effect of the degree of the school-age child's health on our responsibility for doing or not doing something about it than we are with its effect on the child himself. We do not take the opportunity often enough during the evaluation to determine what the child perceives about himself and what he thinks about the evaluation. For instance, do we know what he thinks of the procedures?

We do not always consider what each of the many people the child has to deal with perceive about him. Do we know what other people are doing *to* or *with* him, what they are saying to him? Do we know what *he* thinks about it all?

Perhaps if we approached our evaluations of children with these questions in mind they might be more successful in producing permanent health improvements.

I think it is obvious by now that I believe that, in order to improve the health of children of school age, we need to be sure that we:

1. Appreciate the many factors in the child's growth and developmental process and are prepared to base our efforts toward improving them on a sound evaluation of each child.

2. See that a continuing and balanced evaluation process is provided from birth through adolescence which has as its objectives: prevention of illness and abnormalities; detection and correction of defects with appropriate modification of the child's living and learning patterns; evaluation of his physical, emotional, social, and intellectual potentials; and health education directed toward motivating the child to successfully achieve these goals for himself.

3. Use careful and complete evaluations of the child which are appropriate to his age level and are coordinated with other information available about him as the basis for appraising the procedures and programs we now use to achieve improvement in his health during school-age years.

4. Include the child himself in the evaluation of himself, recognizing that our examples educate the child—for better or worse—whether we want them to or not.

5. Provide productive methods for communicating to *all* persons working with the child our knowledge about him as he progresses from one age period to another so that this knowledge can be used to the fullest extent to improve the child's total health.

It is equally obvious that I consider the health of the child of school age to be a joint responsibility of all persons working with him—his parents, his educators, his social workers, as well as his health counselors, including his personal physician and dentist as well as health department personnel and even the child himself.

Physicians and dentists in private practice, who have the primary responsibility for the health of most of the children in any community, need to take a greater share of this responsibility than many of them do. Probably the most basic problems confronting both the private practitioner and the many other people working with the child of school age are:

1. The wealth of information the physicians and dentists frequently have about the child is not effectively communicated to the educators.

2. The physicians and dentists are not made aware of what information about the child's health is of most value to the educators.

3. The ways in which children of school age need evaluating and the best method for each community to use in making these evaluations are not clearly understood.

Determining the solutions to these problems requires not just cooperation but also the real and active assumption of appropriate responsibility by the individual physician, dentist, and educator concerned—not just representatives of their groups.

However, if each of us carries out his responsibility *alone*, no matter how well we do it, the child gets lost "between the cracks." Unless we determine *together* where each of our responsibilities lies in the continuum of the child's life, unless we sit down and plan *together* what we want our objectives to be and then proceed to carry them out *together*, and unless we make it possible to make this communication a *continuous* one, we will be making a selfish approach, putting our own needs first rather than subordinating them to the child's.

The general basic objectives can be determined and overall responsibilities assumed at the State level in the departments of health, education, and welfare, in the medical and dental societies, and in the parent-teacher associations. But the specific application of these objectives and the definitions of responsibility have to be finally made by the people in the local communities, which vary widely in availability of professional people and facilities and in interest.

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[1] Fuller, Edmund: The writer and the clinic. Saturday Review, April 21, 1958.

[2] Lesser, Arthur J.: Changing emphases in school health programs. Children, January–February 1958.

# THE VALUES OF LIMITS IN CHILD REARING

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WHEN WE CONSIDER the values of limits in child rearing we are approaching a subject that is crucial not only to the future of each child, but also to the future of our Nation and its role in the world society. In setting limits for the child we foster the development of personality strength and in our decision as to what the limits shall be we communicate our personal and cultural value system. These two qualities, strength of character and conscience, in the individuals who make up our Nation are vital determinants of both the extent and nature of our influence in world affairs.

To discuss the subject of child rearing we need to think first of our goal. In our age we stress the importance of mental health, and we appropriately can state that its achievement is our overall goal.

What is mental health? The Group for the Advancement of Psychiatry, in its report entitled "An Outline for Evaluation of a Community Program in Mental Hygiene," states that "mental health can be defined as a state of well-being, of efficiency at work and of harmony in human relationships."[1] This definition takes note of the fact that the individual also is a member of a society of human beings. From the viewpoint of mental health, our goal in child rearing, therefore, would seem to be twofold: (1) To help him achieve a personal state of well-being and happiness, and (2) to help him become a productive, well-socialized member of the family of man.

Focusing for a moment on the second part of this goal, it is important to remind ourselves that the parents, the responsible members of the family group, really are the agents of society. Parents who fail to perceive this responsibility adequately and to accept it deprive themselves of the conviction, the strength, and the emotional support which comes from working with others toward a goal which gives purpose and direction to the rearing of the child.

As one example: The threat posed by recent Russian scientific achievements has made us all acutely aware of the importance to our Nation of the child of today because of the responsibility to which he falls heir in the world of tomorrow. Right now there is much reevaluation taking place in regard to many aspects of our Nation's activities. In the reevaluation of our educational system, the possibility arises that "child-centered" educational policies, with an overemphasis on making learning easy and fun, may have been working contrary to the best interests of our country. My experience leads me to believe that a similar philosophy has been followed by many parents whose well-intended desire to make things easy for their children has handicapped rather than prepared them for meeting the realities of life.

## *What Are Limits?*

The use of limits is essential to the task of preparing a child for the realities of life. What is involved in setting limits?

1. The limit must be based upon a sound value judgment.

2. The limit once set must be adhered to firmly.

3. The child should be encouraged to seek and work out his own solution to the problem which the limit poses for him.

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**Based on a paper given at the Conference on Family Living, Family Service of Philadelphia, 1958. In connection with this revision the author has taken into consideration points raised by Miss Beulah Winstel in her discussion of the original.**

4. The parent must give understanding and guidance, and help the child to find alternative (sublimative) behavior patterns.

In carrying out this plan, the parent who acts with consistency and firmness arising out of conviction about his own values will be much more effective than the parent who acts with tentativeness or exaggerated authority based on doubt and ambivalence. At times, appropriate punishment may be needed to convince the child who fails to comply that the limit indeed is a limit. The necessity for punishment and the form of punishment will vary with the age of the child, with the behavior of the child, and with the personality of the parent.

In general, we know that rigid child training tends to beget either a stifling of initiative or rebellion. We also know that the child-rearing philosophy generally described by the term "permissiveness" arose out of protest against rigid and harsh discipline. What I wish to convey in the term "setting limits" is the concept of "freedom within limits." Speaking now only of the child (although I believe the same holds true for the freedom in a democracy), there is no such thing as freedom *without* limits. The child whose parents have set inadequate boundaries on his behavior is an unhappy child. He is the slave of his own impulses which require him to test every situation anew in an unending search for control.

What then *are* the values of limits?

1. **Limits help establish identity.** In the first weeks and months of life, they help the infant distinguish himself from his mother and from his surroundings. These limits usually are provided by the mother, generally with no awareness that they are such. When she responds to the baby's signals—his crying when hungry or smiling and babbling when gratified—she helps the baby to make the distinction between himself and herself. This is analogous to the manner in which the presence of an object in the physical world becomes known by its reflection of the waves of a radar beam. The infant's touching of his mother's nose and ear, eliciting his mother's affectionate baby-talk response, and his pulling of his mother's hair or biting her shoulder and eliciting her annoyed, angry response, are both examples of such limits.

When the baby is but a few months of age, his mother, usually quite unwittingly, helps him develop the beginnings of self-control. As she recognizes his increasing confidence about being fed, she no longer rushes to give him the bottle at his first signs of hunger. She presents the limit of having to wait, and from this he learns that tension and discomfort are bearable.

2. **Limits provide control.** Early in the child's life the parent provides practically all of the control for the child, not only in regard to stimuli or happenings occurring outside of the child, but also in regard to his inner tensions and feelings. Just as a mother has the power to limit or control the hunger tension by feeding the child at the proper time, so when a child is sick or in pain she soothes his feelings so that they do not overwhelm him from within. The mother also protects the child from exposure to extremes of heat or cold and provides relatively quiet and dark places for sleep. She will protect the infant from anyone who would handle him roughly. This kind of limiting and providing of controls is extremely important in giving the child a good feeling about life at its very beginning.

As the child develops, however, his mother must help him to gain self-control. This is best accomplished by the technique of "freedom within limits." Toilet training is a good example. The average child is able to control the sphincters of bladder and bowel at about 18 months of age because connecting nerve pathways from the control centers of the brain become activated at this time. The mother begins toilet training by letting the child know that she expects him to control bowel and bladder by emptying them in the culturally required manner. This constitutes setting the limit. However, the wise mother knows that the child cannot acquire this control immediately. She also knows that it is important for the child to be cooperative and achieve this as a voluntary self-control rather than primarily from fear of punishment or loss of love.

If the mother does not allow the child the freedom of making up his own mind about this and accomplishing control at his own pace, he is likely to develop either excessive conformity or excessive rebellion. If, on the other hand, she does not present the limit with sufficient firmness and consistency the child acquires this self-control skill belatedly and without the associated satisfaction and self-esteem.

As a somewhat different example, there is the parent who sets the limit of not allowing his 6-year-old boy to have a jackknife, even though the child clamors for it. This parent is not only protecting the child from the possibility of accidental hurt to himself or others, but is at the same time reassuring him about his ability to maintain control over those inner aggressive impulses which premature possession of such a weapon might overstimulate.

Such limits, then, provide a control which gives both a feeling of security and protection from outside dangers, and a feeling of security in not having to fear one's own inner impulses.

3. **Limits stimulate the urge toward mastery.** That there is an inherent drive toward mastery in each child can be illustrated most simply in relation to the mastery of physical forces. When the neuromuscular system has matured sufficiently, the child wants to walk. The first attempts at walking inevitably bring him into conflict with gravity. Although the experience of falling may be physically painful and produce tears, it is the rare child who does not immediately try walking again in order to learn how to deal with this obstacle, gravity. Even in this common experience, however, the parent may be either a help or a hindrance. Although at the outset he usually offers the child some aid in learning to walk, nevertheless he must set the limit of insisting that the child soon learn to walk alone. If parental anxieties lead parents to spare the child his bumps and his tears and to carry him from place to place, or constantly to hold his hand, they are interfering with the child's drive toward mastery. Moreover, they may greatly impair his feeling of self-confidence and self-esteem.

Similarly, in the toilet-training example already given, the limit is set and the mastery drive is called forth at the time the parents present the cultural requirement to the child. If no limit is applied, the child eventually trains himself, but this does not have the same value to the child as having met and mastered the challenge at the earlier age.

The parent who sets the limit for an older child that homework must be done as required by the teacher with a minimum of help from the parent may be frustrating the child and bringing out some resentment or other unpleasant feelings. Nevertheless, he is also calling forth the child's will to gain mastery and to succeed.

4. **Limits result in character strength** by means of identification. There is a phrase often quoted as a bit of homespun advice, "If you can't lick 'em, join 'em." In our adult affairs we tend to think of this as capitulation with a tacit acknowledgment of weakness. In child-parent affairs, this phrase need not carry this bad connotation. A child's recognition of the strength and firmness of the parent produces healthy identification of child with parent, particularly if the parent is a loving parent. Because a child protests a parental decision does not indicate that the decision is wrong or that the child will not benefit from it. To the contrary, if the parent's motive is to help the child, the usual outcome is a consolidation of the child-parent relationship through the identification process.

A 10-year-old boy will complain bitterly when his father tells him that he must finish his job of mowing the lawn before he gets his weekly allowance. The next day, however, he may be overheard to tell his friend next door or his younger brother or sister that it is good for them to finish up something that they set out to do, this advice being given with conviction.

5. **Limits promote personality development.** The values thus far discussed—the establishment of identity, the development of self-control, the fulfillment of the drive toward mastery, and the development of character strength through identification—all contribute to the development of that part of the personality called ego. This active, functioning part of ourselves has the task of gratifying our needs and conducting our affairs in a realistic way. Also developing throughout the childhood years is the part of the personality called the superego. This is our conscience, our sense of right and wrong, and our set of ideals and standards.

At the beginning of life the child has no value judgments except wanting whatever is pleasant and wishing to avoid whatever is unpleasant. Even the culturally prescribed limitations of weaning, toilet training, and certain prohibitions against sexuality seem pointless to the child. He accepts these and other cultural and social values if they are presented to him in a reasonable way by loving parents who give him time to work out his feelings about his frustrations. In the young child the parents provide the function of conscience. Children cannot be depended upon to follow the wishes of the parents, particularly if the parents are not near at hand. As the child matures, however, he gradually takes into himself the values which have been presented to him. In so doing he really is making life easier for himself since he now can behave in accordance with his own internalized rules and regulations rather than having to wonder or worry constantly about the judgment which will be handed down by the parents.

Thus we can see that the everyday decisions and judgments which parents are continually making in setting limits for their child eventually add up to the value system of the child. In the daily living with his parents, however, the child comes to "know" not only the overtly declared attitudes of the parents, but the latent and often unconscious attitudes as well. He does not heed the counsel of the trite saying, "Do as I say, not as I do!"

### *What Is Limited?*

Although I have given examples of some ways in which we set limits for our children, I wish to outline more clearly what is being limited.

**1.** We limit the infantile mode of gratifying oral desires by instituting the weaning process.

**2.** We limit the pleasure and the freedom involved in evacuating the bowel and bladder by insisting on toilet training. From this comes not only self-control, but the beginnings of patterns of cleanliness as well as other personality traits which serve important and constructive functions in our society.

**3.** We limit sexual expression and sexual gratification. Although there may be changes taking place in the cultural mores in regard to sexual behavior, masturbation generally is still censured, especially if excessively or openly engaged in; modesty is encouraged in young children and generally insisted upon in older children; and sexual activity between children of the opposite sexes as well as of the same sex is strongly disapproved.

**4.** We generally limit an excessive amount of dependency and we also limit an excessive amount of independence. So many parents seem to be unsure in the matter of setting limits in these areas that one wonders whether this, too, is undergoing change with the changing culture.

**5.** We limit aggressive impulses by generally taking a dim view of excessive temper tantrums, physical aggression against another person, verbal aggression, property damage, and disobedience. In this area, too, many parents have a great deal of difficulty. In part, these parents seem to be afraid of their own aggression and of the child's aggression; in part they seem to fear that the child will interpret limitation of his aggression as evidence of lack of love from them and they seem to fear loss of love from their child; in part they seem to have a vague apprehension that controlling their child's aggression will somehow stifle his initiative and creativity.

Why are parents today having difficulty in setting and holding to adequate limits for their children?

That we have been living in times of great and rapid technological change is evident. That in these times there also has been great change and much confusion about cultural standards and values appears to be equally evident. Material possessions seem to rate highest in our value system, at least until recently. A great many people appear to seek security, often quite frantically, in the acquisition of money or of those things which money will buy. At the present moment, however, it looks as though technological, scientific achievement may be on the way to becoming more valued than material things. At the same time other value systems, some conflicting with materialistic goals, have also been demanding considerable attention. The oldest and perhaps strongest grew out of religion. Not particularly new, but recently expressed with renewed vigor, is the ideal of world peace.

Thus the changing times have left people with a confusion of value systems and with a lack of belief in the values to which they do subscribe. Hence, parents today lack conviction, lack confidence, lack certitude in regard to themselves and their decisions. They have difficulty setting limits for their children because they do not know where the limits are for themselves. To set a limit is to act on a value judgment; and if one is not sure of what he values, then confusion, inconsistency, and ambivalence result.

That the great majority of people on this earth desire peace, we very likely will all agree, but we follow two quite different roads toward this goal. The one is toward greater technology and greater armament in the hope that the threat of our power will prevent war. The other is through the United Nations and other diplomatic channels in an attempt to reach understanding with other men. This latter approach, I suspect, is basically a matter of conscience. In this country we believe that the national philosophy stems from the individual. If this is true, then child rearing, and with it the setting of limits from which character strength and conscience arise, remains an extremely important responsibility which will continue to deserve our most thoughtful consideration.

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*Do children raised collectively differ from those raised by families? A visitor to Israel reports on . . .*

# KIBBUTZ CHILDREN— RESEARCH FINDINGS TO DATE

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THE ISRAELI KIBBUTZ (pl. kibbutzim) is a unique social and economic experiment in our present-day world. This type of village or settlement in which there is common ownership of everything but a few personal belongings has few parallels in our modern society. It is distinguished not only for its experimentation with overall social structure, but for its innovations and changes in the family structure and parent-child relationships. Because of its economic collectivism, the family unit does not have its traditional economic functions and responsibilities, especially in relation to children.

Children who are born in a kibbutz are considered the charges of the entire community, rather than as "belonging" to some particular couple. To be sure, affectional ties and close relationships with the biological parents are established, but probably with a difference, and under different circumstances than in families elsewhere. Moreover, the socializing function of the family with respect to the children is considerably reduced in the kibbutz. Also the number of contacts between parents and children is reduced while the number between parent surrogates and children is increased.

## *Kibbutz Child Rearing*

Typically, kibbutz children live in peer groups rather than in the family circle as we know it in Western society. When the infant is a few days old, upon return from the hospital with his mother, he is placed in an "infant house." This is a separate building for infants up to about 1 year of age. It is an independent living unit with its own bedrooms, sanitary facilities, kitchen, and other rooms. Usually, there are 4 to 5 infants to a bedroom. They are cared for by a nurse especially trained for the purpose.

The function of the nurse is not regarded as that of a mother substitute, but as a supplementary mother. The feeding of the infant and sometimes washing and putting him to sleep during the first few months of life are done by the mother, who is free from any other duties during the first 6 weeks following the child's birth. The nurse, however, watches over the baby, checks his health, and administers whatever supervision is necessary when the mother is absent. The infant sleeps in the infant house, not in his parents' room or apartment. Only in cases of severe illness or contagious disease is the child removed from the infant house, usually to "isolation" in the infirmary; sometimes to the parents' room.

Following the weaning of the infant, his care becomes more and more the responsibility of the nurse. She usually starts with a group of 4 or 5 infants or young toddlers of about 1 year of age and carries them through age 3 or 4 when they enter kindergarten. When the children have reached kindergarten age, 3 or 4 of the smaller groups combine into a larger unit of 12 to 18 children. This group is cared for by a nurse and an assistant and is taught by a kindergarten teacher during the day.

The children's contacts with the parents, during this period and during the subsequent years until maturity is reached (age 18), are confined to late afternoon visits with them for an hour or two, and to longer periods on Saturdays and holidays. On these days the children spend about 2 hours with their parents and true brothers and sisters in the morning and frequently several additional hours in the afternoon. The time may be spent in the parents' room or apartment, outdoors, or even on short trips to nearby communities.

The child-rearing circumstances just described are typical of those in most of the 200 or so Israeli kibbutzim, which contain about 5 percent of the total Israeli population. Ever since the establishment of the first kibbutz in Palestine some 50 years ago, there has been a good deal of experimentation with the educational system in them as well as with methods of agricultural and industrial production, security, division of labor, and other aspects of the society. The regimen described here has become more or less stabilized as a regular framework for infant and child rearing.

Needless to say, a number of questions come immediately to the mind of the Western man and, especially, to the mind trained in the West in the behavorial sciences. The chief one is: "What kind of person results from this different upbringing?" This is quite a complex and global question. It may be split up and subdivided into a number of more specific questions.[1 2] These, and the answers so far found to them, will emerge in some of the later sections of this article.

Since the relationship between early-childhood experience and later personality development, in all its ramifications, is the focus of interest in modern psychodynamics, as a clinical and behavior scientist, I, too, have been puzzled by the possible effects of kibbutz child rearing on later personality development. Therefore, I decided to devote the year of my sabbatical leave (1955) from Michigan State University to the investigation of some of the aspects of this question. This article is in the nature of a progress report regarding the findings obtained so far. These findings are based on a larger mass of data gathered during a stay of 11 months in Israel.

### *The Research Program*

The ideal approach, in the study of the effects of early-childhood experience upon later personality development, would be a longitudinal study—one which would trace the development of children in

**Teen-agers in a communal dining hall in a kibbutz near Tel Aviv. Research indicates that kibbutz-reared teen-agers are educationally ahead of their peers reared in farm families but behind them in explicitness of plans for the future.**

kibbutzim from birth to maturity, over a period of years. However, the few longitudinal projects of child development in the United States, although very fruitful, have encountered a good many methodological difficulties. Considering the temporal limit of 1 year in Israel and some of the methodological difficulties, I decided to adopt a cross-sectional method of study, to investigate groups of kibbutz children at different levels of development, using the assumption that the older children in the study are like the future 10-year-olds who were the infants in the study.

I decided to sample three groups of children at different stages of development—from infancy to late adolescence. These children were obtained from about a half dozen kibbutzim in which child-rearing practices are in accordance with our earlier description. In addition, we studied three groups of like-age Israeli "control" children. That is, for comparative purposes, we investigated parallel groups of children who were reared in ordinary Israeli villages in which the nuclear, patriarchal type of family organization is the rule.

### *Infant Study*

Twenty-four kibbutz infants between the ages of 11 and 17 months were examined and compared with a similar group of nonkibbutz infants. Our concern was particularly with the social, speech, motor, and sensory development of these infants. Interviews with parents and nurses, as well as direct observation and testing with standardized scales, were the procedures employed.

The findings obtained with these infants tended to favor the nonkibbutz children. Although the two groups did not differ in respect to sensorimotor coordination nor in respect to gross muscular activity and motility, they did differ in the personal-social area. Despite the fact that they were cared for in groups from the day they were born, the kibbutz children did not seem to respond as readily to other persons as did the nonkibbutz infants. Moreover, their overall developmental quotient was below that of their nonkibbutz peers.

It would seem that the absence of the type of continuous mothering found in the ordinary family as we know it tends to handicap the kibbutz children and delay their development, particularly in the area of social responsiveness. The kibbutz infants seemed to be more listless and unconcerned than the control children, possibly because they were greatly frustrated by the fact that the nurse's attention had to be equally divided among several other tiny roommates.

Mother and child of an Israeli kibbutz during one of their visits together. The child is cared for in an infant house.

The question immediately arises: Does this comparative developmental retardation in the kibbutz infants persist, and is it a reliable predictor of subsequent development? In other words, the question is whether retardation and behavioral difficulties will characterize the later childhood periods of these infants, as reported about children reared in institutions and orphanages.[3] In order to attempt an answer to these questions, two groups of older children were also studied in some detail.

### *The Ten-Year-Olds*

Some 30 kibbutz 10-year-olds (fourth graders) were studied fairly intensively along with a similar number of nonkibbutz Israeli village-reared children. One of the marked differences between the groups was noted in their attitudes to me, a stranger whom they had never seen before. The kibbutz children seemed unreservedly, unabashedly, and openly friendly. They expected the same degree of frankness and friendliness from the strange adult. They were generous with their possessions and were readily willing to share without expecting anything in return. For example, when I was about to leave one of the kibbutzim in which I worked, a little 10-

year-old came up to me with a handful of corn seed, gave it to me and said: "It is too bad you cannot live with us in the country and enjoy our gardens. Here, you are going back to Jerusalem; plant these and you will have a garden of your own!"

The nonkibbutz 10-year-olds were not quite so open and trusting as their kibbutz counterparts. They tended to eye the stranger a bit more suspiciously. They were not as ready to share personal experiences as well as objects which belonged to them. They were more reserved.

These observations, however, are rather subjective and impressionistic. The bulk of our results and corresponding conclusions is based on a variety of projective techniques, some of which were administered individually and others in groups. In this limited space, it seems better to discuss the comparisons between the groups based on the devices employed rather than to describe the techniques themselves. Suffice it to say of the latter that in addition to case-history materials, data with the Goodenough Draw-a-Person, Rorschach, Blacky, and sentence-completion techniques were obtained.

As already mentioned, an answer was sought to the question of whether the comparatively unfavorable psychological development of the kibbutz infants tends to persist and continue into childhood. My results would dictate a categorical "no" to this question. My measures of psychological development—intelligence [4] and emotional maturity,[5] seem to indicate not only that kibbutz 10-year-olds are not behind the control group, but in some ways are ahead.

The evidence points to a somewhat *higher* level of intellectual development and emotional maturity in the *kibbutz* children. The previously noted trend in infancy has become reversed. Something happens to kibbutz children between the ages of 1 and 10 years which helps to overcome the earlier obstacle, and more than makes up for earlier shortcomings.

My own data are not designed to answer the question at what stage in the child's development the reversal of the trend begins and what the important causes and ingredients of this process are. This would require applying the longitudinal approach or studying groups of children at *each year level* between 1 and 10.

### *Attitudes Toward Parents*

My aim was not only to study quantitative differences between our groups, but qualitative ones as well. Apart from the overall level of psychological maturity, in what ways do the kibbutz children diverge in their attitudes from the other 10-year-olds? A number of interesting findings were gleaned from our data. In the first place, despite the fact that the kibbutz children do not live "at home" with their parents and siblings as part of a tightly knit family unit, most of them showed positive attitudes toward their families.[6] Such attitudes were clearly positive in more of the kibbutz children than in the nonkibbutz children. In addition, a kibbutz child tends to have a rather strong identification with his family and a tendency to feel that it is better than other families.

Kibbutz children at work on their school farm. This farming is for educational purposes only and is unrelated to the adult economic organization and structure of the kibbutz.

These trends are not outstanding, but at least the family unit appears to be a rather meaningful concept to the kibbutz child, though it does not exist as an economic unit nor as the outstanding socializing agent in the life of the child. A similar trend shows up with respect to attitudes toward individual parents. Among the 10-year-olds in our study, as many, and in some regards more, kibbutz children regard parents in a positive light as do nonkibbutz children. Perhaps the nurses and teachers, in carrying out most of the discipline and directing the socialization of the child, drain off onto themselves whatever hostility and ambivalence arise in the children as a reaction to the frustrations of training. This explanation has also been suggested by other observers, who have pointed out that the parents in the kibbutz, because of the limited time that they spend with their children, are very permissive and indulgent—like grandparents.[1]

Related to the attitudes toward family and parents is the phenomenon of sibling rivalry which looms importantly in the atmosphere of the ordinary family. Our limited information points in the direction of rare occurrences of intense sibling rivalry among kibbutz children.[7] From a very early age, the kibbutz child is reared with a group of like age but biologically unrelated "siblings." He knows of no life without these "siblings." He is used to having them around, having lived and shared with them from the very beginning of his existence. The experience of having to share, therefore, is less traumatic than with the child of an ordinary family when a new sibling "appears" on the scene. Among the kibbutz children whatever rivalry may have been present in the peer unit in infancy, has long been worked out in the daily interaction in which sharing and cooperating are positive dicta and principles. Some carryover of the resulting attitudes into the biological family is inevitable.

In the ordinary family children usually identify strongly with the parent of their own sex. Boys imitate their fathers and want to be like them; girls want to be like their mothers. The parents are the nearest models and the closest ones emotionally. In the kibbutz, however, the situation is much more complex. There are *several* significant figures in the life of the child—the parent, the nurse, the teacher, and the peers. The nurse, teacher, and peers are frequently, and over longer periods of time, much nearer to the child than are the parents.

**In front of a kibbutz children's house, parents, after work, come to pick up their children for a daily visit with them.**

Thus, it is not surprising that our findings indicate a more diffuse identification among the kibbutz children. The models to emulate are not restricted to the same-sex parent; other figures, including peers and siblings, tend to serve as models for the child. The group cultural norm is therefore more readily absorbed than the individual personal norm of the parent.

## *Goals Differ*

Closely related to identification are goals, aspirations, and expectancies. Aims for the future seem to become crystallized earlier in nonkibbutz children than in kibbutz children. This fact may be due, in part, to the more specific identification of the child in the conventional nuclear family. However, the broader social organization may also be an important factor.

Most of our nonkibbutz children who were growing up in typical farm families had begun to be involved in the economic functions of the family unit rather early in life. It is quite common for a 10-year-old child to have some work duties at home: gardening, feeding the chickens, and even milking a cow or two. Such work experience helps him to think about future occupational goals. Moreover, he also has considerable freedom of choice in relation to his plans for the future.

The kibbutz child grows up in a "children's society," and aside from the chores of keeping his house in order with the help of the nurse, his "work" experience in the garden and field is play or education, unrelated to the adult economic organization and structure. Moreover, he knows that when he grows up he will have to do "what the kibbutz needs." Therefore, we find the kibbutz children are concerned with more immediate recreational and avocational goals, whereas their peers in the parallel nonkibbutz group are more concerned with occupational choice and long-range planning.

Paradoxically, however, more kibbutz children are concerned with broader, impersonal, and altruistic goals. Many of them in the study expressed hope that "there will be peace in the world" and that "there will never be war again," whereas hardly any of the nonkibbutz children showed concern about such broad, cosmic issues.

A good deal more data were accumulated on these groups of 10-year-old children, but these are not yet sufficiently analyzed to produce defensible conclusions or generalizations.

### *The Adolescent Groups*

Finally, 25 kibbutz-reared adolescents (17-year-olds) were compared, in a number of dimensions, with a group of nonkibbutz high-school youngsters of the same age. Although the data on these groups have been less completely processed than those of the infants and 10-year-olds, a few generalizations can be drawn.

The intellectual advantage of the kibbutz children seems to be maintained in adolescence. In written material, the kibbutz adolescents show greater range and complexity of ideas. They also show more interest in education and intellectual pursuits than do their peers of the ordinary farm families. Their interest in education and self-improvement seems in a way to compensate for the absence of long-range occupational goals. The diffuse identification of the kibbutz child may also be a contributing factor.

Despite a great amount of evasiveness—common in the investigation of adolescents—the data on 17-year-olds also indicate the trend, shown among the 10-year-olds, regarding attitudes toward family and parental figures. The attitudes of the kibbutz adolescents are at least as frequently positive—and in some instances more so—as those of the nonkibbutz adolescents. There do not seem to be any serious obstacles to the maintenance of such relationships and attitudes throughout the developmental period.

Another area on which we have some material concerns sexuality. The kibbutz adolescent seems to reflect a much stricter, almost rigid, code with regard to sex than does the nonkibbutz adolescent. For the kibbutz 17-year-old having complete sex relations before marriage is unthinkable—"it would ruin one's life." He rejects the idea with greater scorn and finality, generally, than does the nonkibbutz boy or girl. Perhaps the close interaction between the sexes in the living quarters in the kibbutz, and their continuous physical proximity, dictate the use of a more powerful regulation of sexual behavior.

A number of other comments about the 17-year-olds might be made, but not without the risk of insufficient support from the data.

### *In Conclusion*

Cross-cultural data of the kind just described give us an opportunity to look at our beliefs, concepts, and principles with additional perspective and objectivity. If not all "sacred cows" remain unscathed, this is all to the good. In all areas of life we need to examine occasionally the alleged universality of our principles. The child-rearing process is no exception.

The question of "how good" is child rearing in the kibbutz cannot be answered categorically and out of the social context. The last 40 to 50 years have shown that the kibbutzim have reared many young men and women for effective membership *in a kibbutz.* The effectiveness of this new generation is judged by kibbutz standards—by standards of the society which they perpetuate. How effective and how adequate a kibbutz-reared person may be in *another* social context is a question remaining for future investigations.

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*Steps for filling the gaps in services to children are suggested as . . .*

# CHALLENGES TO CHILD-WELFARE ADMINISTRATORS

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WE HAVE long been committed in this country to the principle that basic child-welfare services should be available for the protection and care of those children who need them. Federal responsibility for helping establish and for encouraging the extension of such services was written into the Social Security Act when it was passed in 1935. At that time, many States were already doing something about homeless or mistreated children. The Social Security Act, however, resulted in the establishment of public welfare agencies in all States. It also resulted in State statutes placing responsibility for the well-being of children with this new State agency. The wording of these statutes is usually broad and all-encompassing. They ordinarily constitute a charge upon the State agency to do those things which are necessary to protect children and to provide adequate standards of care.

As a result of these developments, we have today in this country a vast network of State and local public agencies providing services to children. In March 1957, public welfare services not related to financial assistance reached 329,688 children.

The Children's Bureau of the Department of Health, Education, and Welfare estimates that $159 million were spent for such services during the year ended June 30, 1957. This is an important contribution to the lives of a large number of children. However, a careful look at the status of child-welfare services in this country today reveals many serious problems. A comparison of existing services with the needs of the present, rather than with the deficiencies of the past, can only result in grave concern for the well-being of children throughout the Nation.

One of the goals of public child-welfare programs from the beginning has been to make available certain basic services in every political subdivsion in the country. We have been far from successful in achieving such coverage. The fact that every State has a child-welfare program does not mean that services are readily available throughout each State. In fact, many States include vast areas where basic services are essentially unavailable and where dire emergencies in the lives of children bring forth only meager community endeavors in their behalf.

In 1957 only half the Nation's counties had available the services of caseworkers who were giving full time to child welfare. Some of these full-time child-welfare workers were spreading their efforts over many counties. Of course, in some of the counties having no full-time worker adequate child-welfare services were no doubt being provided by workers who also carried responsibility for other services. In many counties, however, practically no casework services were available to children. We can only conclude that in these counties many children are growing up neglected and mistreated and that where the court or some other agency steps in to prevent the worst from happening, only makeshift arrangements are available to meet their needs.

## *Gaps in Services*

The picture becomes even more dismal upon examination of the facilities and services which are actually available in those counties having child-welfare-service programs.

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**Based on a paper presented at the 1958 forum of the National Conference on Social Welfare.**

Children whose parents neglect or mistreat them, children whose parents misunderstand them, children who are in danger of becoming delinquent or who have already been involved in delinquencies need a broad variety of child-welfare services. Let us examine briefly what some of these necessary services are and how widely available they are to children.

Most public-welfare programs began with emphasis on the provision of foster care. Situations in which the problems of children have become so serious that they can no longer live with their own families are dramatic and emergent. It is not surprising, therefore, that the provision of foster care has been the most extensive of the public child-welfare services. Even here however, there are large deficiencies both in coverage and in the quality of the service provided.

In 1956, the Children's Bureau made an inquiry in all States concerning the adequacy of their foster-care programs.[1] The results of this inquiry showed that although in most counties some court or social agency was charged with the responsibility for providing foster care for children, in vast areas where only meager emergency services were provided: 49 of the 51 responding States and Territories reported children needing foster care who were not receiving it; 38 reported children in institutions who could have profited from foster-family care; 45 reported need for additional foster-family homes; 45 expressed a need for residential treatment centers for emotionally disturbed children. No one examining this report can fail to be impressed with the need for radical extension of this earliest recognized phase of child-welfare service.

### *Permanent Homes Needed*

During recent years much time and thought have been given by administrators of public child-welfare agencies to the subject of adoption. As a result, much more use is being made of this method of providing a permanent home to children whose own families have failed them. But here, too, we have a long way to go.

In 1956, 43 percent of the children adopted throughout the country by unrelated petitioners were placed without the benefit of social-agency services. Thirty-six States reported in the Children's Bureau survey on foster care in 1956 that they had children in foster-family care or in institutions who should be in adoptive homes. Much must be accomplished before the possibilities of adoption are translated into the reality of permanent homes for the large numbers of children now floating from temporary arrangement to temporary arrangement.

During recent years child-welfare workers have been talking extensively about the importance of each child's own family. As we have worked with hundreds of thousands of children in foster care, we have learned that there is never a complete substitute for the child's own family, and we have been impressed with the important influence of a child's parents, for better or worse, upon his future. This has resulted in more casework service to parents of children in foster care, aimed at reconstructing families.

We have also begun to raise the question, "Why wait to apply these services until after children have had the terrible experiences that lead to removal from their families?" Similarly, child-welfare workers who have been close to delinquent children either in courts or in training schools have been impressed by the long histories of neglect, misunderstanding, and sometimes cruelty. Here, too, the question is raised, "Why wait—why not apply casework skills at an early stage?"

Therefore, as family problems affecting the well-being of children become apparent, we are beginning to take our services to these families in time to prevent more serious difficulties and to enable children to remain with their own parents.

This concept of applying services early to prevent the development of more serious problems has been intellectually accepted for several years. One might expect that by now it would be the major emphasis of child-welfare programs throughout the country. Certainly child-welfare workers should not be satisfied until the time and energy put into holding homes together far exceeds that spent in foster care. However, most child-care agencies are still using the bulk of their resources in the provision of foster care, in either boarding homes or institutions.

In December 1957, 38 percent of the children receiving casework services from State and local public child-welfare agencies were in their own homes; while the other 62 percent were in foster homes, institutions, or elsewhere. Significantly, from 1946 to 1957, the number of children receiving services (unrelated to financial assistance) in their own homes increased by 22 percent, while those in foster homes increased by 37 percent. We have far to go in translating our visions concerning the strengthening of family life into the realities of positive services.

The same may be said concerning the development of programs providing auxiliary services to families, such as homemaker and day-care services. Although public agencies are taking an increased interest in these fields, the places where this interest has been translated into service to parents are few and far between. The Children's Bureau reports that homemaker services are available in only 150 of the 3,100 counties in the United States. Of the 145 local agencies providing these services, only 34 are public welfare agencies.

Although in 1957 about 7 million mothers of children under 18 were employed, a 52 percent increase from 1950, there is no evidence of anything like a comparable increase in time and attention to the child-care problems their working entails. Day care still remains a minor interest for many State welfare departments.

Since 1948, the number of children reported as coming to the attention of juvenile courts throughout the country because of delinquent acts has increased by more than 100 percent. This is too great to be written off as a statistical error. Instead, it must be recognized for what it apparently is, tangible evidence of serious maladjustment in an increasing number of youngsters in our present-day civilization.

This mass of unhappy youngsters presents a challenge to the field of child welfare such as it has never had before. They require a whole battery of services from various sources, but one need they have in common is for casework, the special commodity of child-welfare services. Many of them need foster care and have needed it for years. Many more of them are badly in need of help with problems within their families.

If we are to cope with the problem of delinquency, we must, in every State, have a strong agency providing leadership in the attack. Public child-welfare agencies are in an excellent position not only to provide necessary services, but to fill this leadership role as well. However, most State welfare departments make no special claim to responsibility in this field and are not actually giving the leadership which is required. In only a few States are the public-welfare agencies tackling this problem vigorously as a special assignment. In a few others, special agencies have been set up for the purpose. In the vast majority of States, aggressive leadership is not forthcoming. Here public welfare faces one of the most important challenges of the day.

Thus, when we survey child-welfare services in this country in relation to what appears to be emergent present-day needs, the picture is far from encouraging. Moreover, although there has been a great increase in the volume of service provided by public child-welfare agencies over the years, these increases have in actuality over the last 10 years fallen far behind the increase in the total child population. Information from the Children's Bureau based on reports from 40 States shows that the number of children receiving child-welfare casework services from public-welfare agencies increased on an average of 25 percent from 1946 to 1957, but that the population under 21 in these States increased 34 percent in the same period.

### *Obstacles to Progress*

What are the obstacles which are preventing the expansion of child-welfare services to meet needs known to exist?

Often, we in the child-welfare field tend to project our difficulties on other people; we talk about the legislature that did not act; the Governor who would not go along on certain projects; the public's lack of interest; meager appropriations. I was amazed, however, when I recently made a list of what seemed to me to be the major obstacles, to find how many of them actually lie, at least partially, within the control of those of us who have responsibility for the administration of child-welfare services—boards, administrators, child-welfare directors, supervisors, caseworkers, and others. Although we are faced with serious obstacles, there is really no reason to feel helpless. There is much within our own control that can be done to expand and strengthen services.

One of the first problems to be overcome is our own lack of vision. Too many of us are content with being successful at our own little piece of the job and do not give much thought to the broader aspects of child welfare. We are not going to make the necessary substantial headway unless more of us catch the vision of broad child-welfare programs reaching all people needing them, in time to be most helpful.

We must not be afraid to "think big." Not much ground will be gained by small measures. The services which are needed will cost money and require a large number of people to man them. We tend to be too pessimistic about the public's willingness to do things for the well-being of children. Our failure to move ahead may often be due to our own failure to ask for enough.

The person who continually cries that we can try nothing new because we are not doing well the things we are doing now will not furnish the kind of leadership needed for the future. The theory that we should do only those things for children which can be done on an extremely high professional plane can no longer hold. It has been tried in the past and has been helpful in meeting the needs of a few children. This approach can never be depended upon to provide child-welfare service coverage throughout the country or to make available the basic services which in so many communities do not now exist.

When did anybody in the field of social work ever start a new project of any substantial proportions with an adequate staff? We just don't move forward that way in a democracy. We accept responsibilities. We get the best help we can and we tackle the job. If we play our cards well, more staff is forthcoming and eventually we may make a major contribution. If we do not, we may fall flat on our faces. This is the risk we have to take.

### *Personnel Needs*

On the other hand, we do face in this field serious problems resulting from the lack of trained, experienced personnel. This is unquestionably a grave obstacle.

The low evaluation placed by the public upon social workers, teachers, ministers, psychologists, and others responsible for guiding children puts all of these professions at a disadvantage in recruiting and holding personnel. Child-welfare services share in this disadvantage.

We will know much more about what motivates persons to leave child-welfare assignments when a survey currently being conducted by the Children's Bureau and other national agencies is completed. Although the question of compensation is no doubt important, there are other factors which may play as important a role. These have to do with skill in selection, the kind of working conditions provided, and the supervision and understanding of the job given to the workers. These last are factors certainly in our power to influence. While salaries must be improved, a vigorous attack on these other administrative problems might prevent some of the annual turnover in professional child-welfare positions, which now reaches 27 percent.

Actually, the public child-welfare field has done an outstanding job in recruiting and training personnel. By 1950, this part of social work had progressed well beyond the field as a whole in the percentage of its staff having full professional training—20 percent in child-welfare services as compared with 16 percent in the field of social work as a whole.[2] In 1955, 28 percent of persons holding child-welfare positions had 2 or more years of professional education, and another 25 percent had at least 1 year of professional training; 8 percent had some training but less than 1 year. Thus a total of 61 percent of the 4,871 professional persons employed in public child-welfare programs have had at least some graduate education.[3]

This good record for child welfare is, in my opinion, largely due to the Children's Bureau efforts to promote personnel standards and to a liberal use by State welfare departments of Federal funds for educational leave. Nevertheless, the number of grants budgeted by the States to be made to persons for educational leave steadily dropped from 1952 through 1955 from a high of 624 to a low of 352. While this trend has since been reversed, if we are really interested in obtaining personnel for child-welfare services we must make sure that such a drop does not again occur. It is encouraging to note that the amount budgeted by the States in 1958 for educational leave is at an alltime high.

Public-welfare experience has shown that a skilled supervisor can frequently obtain good casework service from a staff whose members have been well selected, but who are untrained. If the child-welfare field were today to be faced with the immediate possibility of great expansion, it could look to a strong nucleus of trained personnel already in the program who could provide leadership and who could, with the help of an increased number of untrained persons, produce a tremendous amount of good work for children. This is a potential which must not be overlooked in considering what we are able or unable to tackle in extending child-welfare services. Personnel problems present an obstacle but there is no reason to think that it is insuperable.

### *Administrative Problems*

Another difficulty plaguing child-welfare leadership in many States is a lack of administrative clarity. There is no consistent pattern of organization in State welfare departments throughout the country. Patterns vary with differences in the nature of services, tradition, and the concepts of current administrators. But in any pattern those in charge of the child-welfare program need a clear area of administrative responsibility, which will allow the child-welfare unit to influence easily what is happening locally where services are applied.

A frequent problem arises from the efforts of State welfare administrators to establish a direct line of supervision, without program differentiation, to local units. I do not question the State administrator's need for this, nor do I think it unworkable to include in the functions of the line staff some basic responsibilities for carrying out child-welfare operations. Problems arise, however, when the line staff begins to formulate policy in child welfare and to exclude the child-welfare unit from any responsibility for local operations.

In order to make its influence felt upon local services, the child-welfare unit must have operational responsibility. If this is carried out through the line field staff, the child-welfare unit should provide consultant services available both to the field staff and the local agency, thus keeping the State child-welfare unit directly tied in to local operations.

Another set of administrative problems involves relationships between local public-welfare agencies and State agencies. These vary in nature, but they all result in weakening the influence of the State agency on the local operation. In some States an excessive regard for local autonomy may result in a failure to provide the State agency with the powers and tools for carrying out its policies, thus preventing it from exercising leadership. In others State leadership is not effective because the State agency does not take a clear-cut, definite stand and hesitates to take issue with local agencies when differences occur.

I strongly believe that child-welfare services should operate under the same administrative roof, both State and local, as other public social services. It seems to me entirely unrealistic for 2 local public casework agencies, 1 for child welfare and 1 for other services, to exist. It also seems to me that we need to look carefully, and at once, at the basic administrative structure and legal framework for child-welfare services in many States in order to be sure that they lend themselves to effective action. Where a hodgepodge of laws affecting children divides responsibility for child-welfare services among a variety of agencies, or where no public agency has authority to provide certain kinds of needed services, children are the losers.

Closely allied to the problems in administration are those related to the financial structure. In contrast to public-assistance programs, where the Federal Government is making major contributions to the actual cost of administration and assistance, the bulk of the cost in child-welfare programs is carried by State and local governments. Since the Federal Government does not share in the cost of child-welfare administration and services on a percentage basis, the stimulation for coverage within the States and localities is not so great. Federal funds for child-welfare services are primarily stimulatory in nature and useful for developing new programs. Careful attention should be given to this financial structure as it has obviously been less successful in solving the problem of coverage than that used in public assistance.

I would also like to see States takes a new look at the way in which they are using the Federal funds. I would like to see this reassessment done in the light of the need for coverage and for broad child-welfare services. It is my impression that considerable amounts of Federal funds are being used to staff established child-welfare services—particularly in foster care—which should have become a financial liability of the States many years ago. With their Federal funds tied up in support of this basic operation some States do not have money available to move into new and different kinds of programs.

## *Telling the Story*

One of the important obstacles to the expansion and improvement of child-welfare programs is the lack of public understanding of the needs of children and of our methods of dealing with them. Until we tell our story to the public through the use of modern communicative techniques, it is going to be very difficult to gain enough public support for the necessary broad extension of child-welfare services.

Child welfare has been handicapped to some degree in achieving public support because of its close association with public assistance. The strong repugnance many people have to the idea of an assistance agency reaching out to distribute funds has made public-welfare administrators extremely timid about the methods they use in public relations, and particularly about expenditures for this purpose.

Actually, the public's attitude toward child-welfare services may be quite different from its attitude toward public assistance. Probably most people would not resent the idea of a public-welfare agency reaching out to help a child, even if it cost some money. What is more appealing than a neglected child, a child without a home, a child in need of protection from destructive adults, a child to be saved from delinquency for good citizenship? These are the children child-welfare workers serve. Their needs stir those of us who work with them and, if known, will stir others. There is no reason why public agencies should not devote substantially more time and effort to telling their story and to explaining what has to be done if their needs are to be met.

The basic responsibility for presenting the needs of these children rests upon the people who know them, the people responsible for working in their behalf and for carrying out child-welfare services. Unless we speak out, it will be a long time before the public is sufficiently moved to demand the services which children must have.

If we are going to obtain for the children of our time what they must have for their protection, we are going to need the zeal of such pioneers as Jane Addams, Lillian Wald, Florence Kelley, and Julia Lathrop. This means going on a modern crusade. It means not hesitating to take advantage of the special interest of the day, such as the current public concern over juvenile delinquency.

We are operating in government. We have to obtain changes in laws and appropriations. We must not hesitate to use political skills and techniques in bringing about necessary action. Much must happen in behalf of children in the next few years, but if it is going to happen, we must first look to ourselves to take leadership in dealing with the obstacles that are today cutting off children from the basic essentials of happy living. If we will really throw ourselves into this crusade, I have every confidence that the public will join us in doing what is needed.

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[1] U. S. Department of Health, Education, and Welfare, Children's Bureau: Foster care 1956. Child Welfare Reports No. 8. 1957.

[2] ———: Educational leave in public child welfare programs; a way to better services for children. Child Welfare Reports No. 6. 1957.

[3] ———: Staff in public child welfare programs 1956; with trend data 1946–1956. Children's Bureau Statistical Series No. 41. 1957.

# FILMS ON CHILD LIFE

**Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.**

THE DEEP WELL. 36 minutes; sound; black and white; purchase or rent.

Portrays the multiplicity of services used in treating children needing care away from home and the use of differential treatment plans related to the children's individual problems.

*Audience:* Members of boards of social agencies; general public.

*Produced by:* Victor Weingarten for the Jewish Child Care Association of New York and the Child Welfare League of America, through a grant from the Eda K. Loeb Foundation.

*Distributed by:* Child Welfare League of America, 345 East 46th Street, New York 17, N. Y.

CAR THEFT. 16 minutes; sound; black and white; purchase or loan.

Suggests what may happen when irresponsible youths "borrow" a car. Includes a chase by police and the death of a child.

*Audience:* Special groups such as police-training institutes, youth-leader sessions, and safety organizations, with a qualified discussion leader.

*Produced by:* Bray-Mar Productions for Buffalo (N. Y.) Youth Board and New York State Youth Commission.

*Distributed by:* For purchase, Bray-Mar Productions, 276 Du Shane Drive, Buffalo 23, N. Y. For loan in New York State, New York State Youth Commission, 66 Beaver Street, Albany 7, N. Y.

SIX, SEVEN, AND EIGHT-YEAR-OLDS—SOCIETY OF CHILDREN. 27 minutes; sound; black and white; purchase or rent.

One of a series of films showing aspects of child development at different ages; focuses on the social development of 6, 7, and 8-year-olds, showing children playing games and taking part in other group activities.

*Audience:* Professional workers for children, teachers in training, students in high-school and college child-development courses, and lay groups.

*Produced by:* Department of Child Study, Vassar College.

*Distributed by:* For purchase, Mental Health Materials Center, 1790 Broadway, New York 19, N. Y. For rent, New York University Film Library, 26 Washington Place, New York 3, N. Y.

VITAMIN DEFICIENCIES IN PREGNANCY. 25 minutes; sound; color; purchase or loan.

Shows effects of vitamin deficiencies on pregnant women and animals, and illustrates results of correction of mild deficiencies.

*Audience:* Students of medicine, nursing, and nutrition.

*Produced by:* N. P. Schenker, M. D., Research and Scientific Films, 330 East 41st Street, New York 17, N. Y.

*Distributed by:* Hoffmann-LaRoche, Nutley 10, N. J.

FAMILY CIRCUS. 10 minutes; sound; color; long-term lease.

Shows in cartoon form how a parent's favoring of one child over another brings trouble.

*Audience:* Parent groups.

*Produced by:* UFA Pictures.

*Distributed by:* International Film Bureau, 57 East Jackson Boulevard, Chicago 4, Ill.

# BOOK NOTES

**ORTHOPSYCHIATRY AND THE SCHOOL.** Edited by Morris Krugman. American Orthopsychiatric Association, New York. 1958. 265 pp. $4.

The 26 papers in this collection are contributed by psychiatrists, other physicians, psychologists, social workers, teachers, educational administrators, and others, from many sections of the United States. The projects described involve preschool and kindergarten groups, elementary schools, junior and senior high schools, and colleges and universities. Both public and private schools are represented.

The editor in his introduction to the book explains that the purpose in publishing these papers is to portray a wide variety of approaches so that the reader may weigh different programs and draw suggestions from them.

**AMERICA'S CHILDREN.** Eleanor H. Bernert. A volume in the census monograph series for the Social Science Research Council in cooperation with the U. S. Department of Commerce, Bureau of the Census. John Wiley & Sons, New York. 1958. 185 pp. $6.

Based on the 1950 Census of Population and a few more recent sample surveys of the Bureau of the Census, this monograph analyzes some socio-economic facts about children and youth in the United States in relation to residence in rural and urban areas and in different regions of the country, and considers their age, race, and sex in relation to residence factors. It reports on the ratio of children to adults of productive age in the different States and shows that States with a high ratio are generally those with low family income, poor housing conditions, low expenditures for schooling, and poor educational performance by the children.

The study points to the fact that over 4 million boys and girls between the ages of 8 and 18 who were in school in 1950 were retarded in their school progress and that the retardation was strikingly high among the nonwhite, the rural-farm, and the southern children. The author, a research sociologist, notes that school retardation often influences children, especially boys, to leave school and seek employment. Presenting figures showing that the predominant pattern of work for young people recently has been part-time employment of students, she urges that more direct investigation be made of such employment to find out whether it hampers or enhances attendance or performance at school.

**THE PSYCHOLOGY OF EARLY CHILDHOOD.** Catherine Landreth. Alfred A. Knopf, New York. 1958. 412 pp. $8.75 trade; $6.50 text.

This textbook on the development of young children's behavior presents the results of research on various facets of such behavior. It includes an account of methods used in studying children's behavior and explains some psychological theories on which studies have been based. Among the subjects treated are: prenatal origins of behavior; behavior of the newborn; development of language; social behavior toward age peers; and perceptual and adaptive behavior.

**NEW FRONTIERS IN CHILD GUIDANCE.** Aaron H. Esman, editor. International Universities Press, New York. 1958. 218 pp. $4.

The nine papers published in this book, all written when the authors were staff members of the Jewish Board of Guardians—psychiatrists, psychologists, research workers, teachers, social workers, and others—deal with a variety of problems concerning disturbed children and of techniques used in treatment. The subjects include: Interpreting test findings to parents; psychotherapy given by a male and a female analyst; supervision in group psychotherapy; clinical groupwork in a residential-treatment center; treatment of atypical adolescents; nursery experience in diagnosis; treatment of the borderline child; the family in the pathological and therapeutic processes; and demonstration of a multidisciplinary approach to the understanding of clinical problems.

**STANDARDS AND GUIDES FOR THE DETENTION OF CHILDREN AND YOUTH.** Foreword by Will C. Turnbladh. National Probation and Parole Association, New York. 1958. 142 pp. $2.

Developed by the National Probation and Parole Association with the assistance of an advisory committee on detention and shelter care for children awaiting court action, this publication presents principles in regard to the use of detention, its administration, staffing, program, and records, and construction of detention facilities.

While focused primarily on program planning, operation, and construction, it also includes discussion of related subjects, such as the role of detention as one of a variety of juvenile-delinquency preventive and treatment services needed by children.

**THE STORMY DECADE: ADOLESCENCE.** George J. Mohr and Marian A. Despres. Random House, New York. 1958. 272 pp. $3.95.

After summarizing phases of the personality structure and growth of the child before adolescence, this book, written by a psychoanalyst and a psychologist, discusses the meaning of adolescence; the psychosexual development of the boy and girl during the adolescent years; character changes; intellectual and creative interests; antisocial and other groups; and the adolescent's search for identity.

A section on mental-health problems of the adolescent discusses the origins of neuroses and psychoses in adolescents, the interrelationship between emotional stress and physical difficulties, preoccupation with suicide, and development of delinquent behavior. The final chapter offers suggestions on what families, communities, and society at large can do to help fulfill the mental-health needs of the adolescent.

The book is addressed to the general public, but contains an appendix with biographical references for persons interested in the sources of its statements.

# IN THE JOURNALS

## *Changes in Childbearing*

Between 1910 and 1950 a number of changes took place in the timing and duration of the period of childbearing in the United States, writes Lincoln H. Day in the June 1958 issue of *Public Health Reports.* ("Age of Women at Completion of Childbearing.") In spite of certain tendencies that lengthened the period of childbearing, the author's study shows that women in 1950 were finishing their childbearing at earlier ages than in 1910; first, because of a decline in family size and second because of a generally lower age of the mother at birth of the first child.

## *A Return to Values*

What some people consider permissiveness in fathers and mothers is more accurately characterized as indifference, says Dale B. Harris in the summer 1958 issue of *Child Study.* ("The Climate of Achievement.") The author, who is director and professor, Institute of Child Welfare, University of Minnesota, urges parents, loving their children and trying to understand their point of view, to set up ground rules for them that will preserve the forms of behavior and ideals of conduct the parents believe important. Among other research on the effects of childrearing practices, he refers to a study under way at the institute he directs which seems to indicate that parents who set standards for their children and observe values build an effective relationship with them—a relationship that the children later regard favorably.

The study compares two groups of adults, matched as to sex and socioeconomic status, who were nursery-school children 30 years ago. All of them had been treated affectionately by their parents. But the parents of one group had held the children to their standards; the parents of the others were casual about child training. The author notes that the young adults who were brought up according to clearly set standards look back more favorably on their childhood relations with their parents than do those of the other group. The former, he says, also tend to show more intellectual efficiency and orientation toward achievement, more interest in and responsiveness to the needs, motives, feelings, and experiences of others, and more concern with how others react to them. They are more satisfied with their jobs and family life, but less satisfied with themselves as persons.

In pleading for parents to make their values clear to their children, the author points out that he is not asking for a return to the authoritarian family in which parents do not seriously consider their children's point of view but for courageous facing within the family of the issue of confused standards.

## *Why Treatment Fails*

A workshop on failures in treating delinquent children was recently held under joint sponsorship of an interprofessional committee on treatment practices in delinquency and the New York School of Social Work, and in the March 1958 issue of *Federal Probation* three of the workshop leaders discuss some of the factors in such failure. ("Why We Fail," by Lt. Jacob Chwast, director of planning and training, Juvenile Aid Bureau, New York City Police Department; Carmi Harari, director of Community Consultation Services, New York City; and Irving Weisman, associate professor, Louis M. Rabinowitz School of Social Work, New York City.)

One possible factor noted is that some technique of treatment stimulates a crisis between the delinquent and the worker, resulting in aggression against the worker—action that necessitates discontinuance of treatment by that worker. Another factor discussed is the claim of the gang or other group on the delinquent's loyalties, which may interfere with effective treatment or may result in social isolation for the delinquent. The third factor brought out is the conflict between the value system of the worker's group and that of the lower socioeconomic group represented by the delinquent. In an illustrative case cited by the authors the worker was unable to treat effectively a boy unconcerned about repeated stealing, because the worker did not know that the boy's father through his indifferent attitude had encouraged the stealing.

Noting that their exploration of sources of failure in treating delinquents perhaps raises more questions than it answers, the authors express the hope that it may point the way to converting more treatment failures into successes.

## *Interracial Observations*

Observations on the behavior of Negro and white preschool children in an interracial nursery school are reported by Margaret B. McFarland, psychologist on the staff of the University of Pittsburgh School of Medicine, in an article in the April 1958 issue of *Psychiatric Communication,* journal of the Western Psychiatric Institute and Clinic, University of Pittsburgh. ("Racial Relationships, a Study of Preschool Children.")

While noting that the children play together "with the camaraderie of their common developmental concerns," the author reports that in their reactions to one another and to the interracial staff they reveal awareness of difference. She also notes attitudes toward colored materials in play—such as paint—which reveal that even at this age children of both races have developed concepts confusing color with values.

Pointing to differences in economic background of the Negro and white children observed, the author reports differences in play behavior resulting from the cultural differences arising from this factor. She also points out evidence of awareness on the part of the Negro children of confusion and uncertainties on the part of white staff members striving to overcome discriminatory feelings acquired in childhood.

## *Adolescent Medicine*

The "psychotherapeutic approach" is underscored as especially important in the medical care of adolescents in an article in the July 17, 1958, issue of the *New England Journal of Medicine.* The article is the third installment of a report, "Recent Contributions to Adolescent Medicine," presented by the Pediatrics Department of Harvard Medical School and the Adolescent Unit of Children's Hospital, Boston, and prepared by three physicians who are on the staffs of both institutions—J. Roswell Gallagher, Felix P. Heald, and Robert P. Masland, Jr.

This concluding installment discusses an increasing interest on the part of physicians in understanding the adolescent patient's personality and psychological needs; medical, psychiatric, and psychological means of dealing with scholastic failure; health-service programs in secondary schools; the value of exercise and games in adolescence; improvement in methods of preventing athletic injuries and of caring for adolescents who incur such injuries; efforts to prevent motor-vehicle accidents and drowning; rehabilitation of physically handicapped young people; and the merits of various methods of treating undescended testes.

## *Therapeutic Day Care*

Besides giving the help to children and parents that any good child-guidance clinic provides, a special therapeutic day-care program for emotionally disturbed preschool children can foster rehabilitation and normal growth in such children, modify the parents' attitudes, and increase the workers' understanding of child development, says Augusta Selligman in *Child Welfare* for July 1958. ("A Day Residential Program for the Disturbed Pre-School Child.")

The author, who is supervisor of psychiatric social work at the Child Development Center, New York City, characterizes the day-care center itself as an ameliorative environment and states that as such it supplements and reinforces treatment. The program as described aims to provide the most beneficial treatment plan for each individual child. If a child's primary difficulty is in social relationships a group program may suffice to promote better adjustment, the author says; if he shows preneurotic symptoms, or marked fears, or a great lag in development, individual therapy may be needed. About two-thirds of the children in the center described by the author receive individual therapy. Representatives of a number of professional fields take a direct part in the program—psychiatrists, psychologists, pediatricians, educators, and social workers.

The author adds that a program of this sort would benefit children other than the most disturbed ones, especially if operated as a neighborhood facility, integrated with other facilities.

# International Publications

PERINATAL MORTALITY. Epidemiological and Vital Statistics Report, Vol. 10, No. 11–12, 1957. In French and English. World Health Organization, Palais des Nations, Geneva. 600 pp. For sale by Columbia University Press, International Documents Service, 2960 Broadway, New York 27, N. Y. $2.

Defining "perinatal" deaths as deaths occurring before, during, and soon after birth, this report uses the term to include late fetal deaths (deaths of fetuses in pregnancies of 28 weeks or more) and early neonatal deaths (deaths of liveborn infants in the first week of postnatal life). It presents statistics from a number of countries on causes of perinatal deaths, and separately on causes of late fetal and of early neonatal deaths. For a few countries figures are given on causes of late fetal deaths by duration of mother's pregnancy and of early neonatal deaths by infant's age in days.

Noting that not all countries use the same definition of fetal death, the report maintains that this difference may have less influence on the comparability of the data than does "the varying degree of completeness with which the late fetal deaths are registered in different countries."

An example of the slight reduction that has taken place in death rates in the first 6 months of infancy as compared with the reduction in the second 6 months is given in a table showing death rates, 1906–55, for England and Wales in various periods of the first year of life.

INTER-COUNTRY ADOPTION. Report of a group of experts organized jointly by the European Office of the Technical Assistance Administration, United Nations; and International Social Service Headquarters. United Nations, Geneva. 1958. TAA/EG/Rep. 3. 47 pp.

Principles for intercountry adoption and recommended government and international action for carrying them out are set forth in this report, made on the basis of discussions held earlier in Geneva, January 21–25, 1957.

Measures recommended include efforts to achieve legislation that recognizes the importance of the welfare of the child in relation to relinquishment of parental rights; to carry out research on several aspects of adoption; to expand and intensify training programs for professional adoption workers; and to plan for exchanges of ideas and experience between countries as a step toward developing and improving adoption practice in all countries.

The report notes that the goal of its recommendations is realization of the basic principle that a child who cannot be cared for in his own home by his parents or close relatives should have a new family and a normal home life in his own country and with his fellow countrymen. Pending achievement of this goal, the committee urges that safeguards be provided throughout the entire adoption process to children who are adopted outside their countries and to their natural and their adoptive parents.

# HERE AND THERE

## *Nutrition and the Mentally Retarded*

An opportunity for professional personnel to exchange knowledge and experience useful for planning and guiding nutrition services for the mentally retarded was provided at a 2½-day institute in June at the University of North Carolina. The institute was sponsored by the university's School of Public Health, the North Carolina State Board of Health, and the Children's Bureau.

Some 70 persons from 23 States participated, the majority of them nutritionists and dietitians responsible for nutrition services for mentally retarded children. They included persons concerned with: developing adequate institutional dietary services; working out satisfactory meal plans for young children suffering from inborn errors of metabolism; advising parents and professional personnel working with retarded children about ways of dealing with feeding difficulties and helping them to recognize and develop the potential for growth and development in each individual child; and participating in research projects.

Resource persons and consultants were available from the fields of medicine, biochemistry, nursing, social work, and education, as well as nutrition and dietetics.

Information on normal growth and development was used as the framework for a logical approach to the subject of feeding a mentally retarded child. The significant role of food in the areas of physical, mental, and emotional development was reviewed along with the differences which occur in the mentally retarded. Out of this came the suggestion that persons working with mentally retarded children also work with normal children so that they may be better able to recognize signs of progress.

The participants devoted considerable attention to the biochemical abnormalities which can cause mental retardation, discussing programs of detection and dietary regimens used for treatment. In regard to phenylketonuria they pointed out that while the development of the associated mental defect can be prevented if a diet low in phenylalanine is started early enough, the high cost of this special diet often poses a great problem for many families, thus indicating consideration of financial assistance for treatment.

Nutrition and diet of mentally retarded children in hospitals, residential homes, other community facilities, and private homes also received attention. The participants considered problems relating to quantity food service, such as those posed by a wide range of age groups, special diets, a recent influx of children of very low mentality, employee training, and staff shortages, but they focused on the nutritional aspects of problems affecting children themselves. These included: the deprivation syndrome; infections and diarrheal diseases; anemias; regurgitation; rumination; disorders of the central nervous system; severe rigidity; and dental problems, especially gingivitis. They repeatedly stressed the necessity of teaching children to feed themselves and of helping parents, attendants, nurses, and others caring for the children to understand the importance of allowing and encouraging this.

Description of some of the clinics and community programs for the mentally retarded emphasized the role of the nutritionist in these programs.

Research needs identified at the sessions included studies of: Prenatal diet as an etiological factor in mental retardation; possible nutritional therapies for some of the newly identified biochemical disorders; methods of providing nutrition services to meet needs of parents and professional personnel caring for mentally retarded children.

—Mary C. Egan

## *Working Mothers*

A research project studying the effects of a mother's employment outside the home on various members of the family and on the family as a whole has been undertaken by the Public Health Service's National Institute of Mental Health, in collaboration with the American Association of University Women and Stanford University. The study is an attempt to determine what kind of women are working mothers—in terms of economic, social, and personality factors—what effect their working has on their family life and homemaking practices, and how this effect in turn affects their children.

Data are being obtained through questionnaires and interviews with mothers and fathers approached through parent-teacher groups in selected schools, and, with a few selected and consenting families, through observations in the home. Included will be information—both on families with employed mothers and on families in which the mother is not employed—concerning motivations, role relationships, child-rearing philosophies, and opinions about maternal employment, as well as on income, educational background, and other social and economic material.

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Two projects currently under way at the Children's Bureau have been undertaken as groundwork for further attention to the needs of children of working mothers. One is an attempt to identify areas of needed research through a review of the literature on the effects of mothers' employment on children. The other, in which the Bureau of the Census is cooperating, is an effort to determine the kinds of care mothers who are working are providing for their children. The information will be gathered through a sample population survey by the Bureau of the Census.

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As a step toward attaining more effective day-care services for children a group of day-care staff and board members from cities in seven eastern States recently held a series of meetings in New York, which resulted in formation of a group called the Intercity Day Care Council. Among the cities represented at the meetings were Baltimore; Boston; Hartford, Conn.; Newark, N. J.; New York; Philadelphia; and Washington.

In the council's discussions members stressed the responsibility of various professions—social work, education, and those related to health in day-care services and recommended that the program of the 1960 White House Conference on Children and Youth include consideration of such services.

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As a step toward helping mothers of preschool children decide whether it is financially profitable for them to work outside the home, the Louisiana Home Economics Association is collecting information from a representative sample of employed mothers concerning their income and expenditures over a 3-month period. The purpose is to find out through determining the true net income of these mothers whether or not many of them would do better if they stayed home instead of going out to work. Another step toward making the financial facts of employment of mothers clear was taken by the association recently when it published tabulations showing the State and Federal income taxes payable at various income levels and also social-security tax deductions at various salary levels.

## *Confidentiality*

As the result of a 2-year study of the meaning of confidentiality in social service to individuals, an ad hoc committee appointed by the National Social Welfare Assembly has issued a report presenting a number of conclusions as a basis for further discussion and action by national and community agencies.

Stressing the need for a strong sense of responsibility on the part of the agency for the interests of the client, the committee includes among other findings the following points:

Confidentiality should not be regarded as a bond of secrecy between client and agency worker, but as a relationship between the client and the agency itself.

Constructive use of information about a client involves not only protecting the information against improper disclosure but also responsible sharing of pertinent information with appropriate persons at appropriate times.

The agency has a dual responsibility, to the client and to the supporting community, which creates many problems in applying the principle of confidentiality.

The agency's board and staff should be oriented periodically on the nature of information about clients and the agency's obligation to guard against its misuse.

Hazards to confidentiality can be reduced if: (1) the client himself is the primary source of information; (2) only pertinent information is sought or given; (3) the client's consent to the appropriate exchange of pertinent information is considered.

Agency staffs need to develop a positive attitude toward the competence and ethics of members of other professions.

The public needs a better understanding of the part played by the principle of confidentiality in facilitating services and hence in protecting the community.

Attitudes toward confidentiality and its application in practice change as conditions change: what once was sound practice may become unsound.

Among other aspects of confidentiality the report discusses the use of actual clients in interpretation and offers some criteria for guidance in such instances.

The report is available from the National Social Welfare Assembly, 345 East 46th Street, New York 17, N. Y. Price 50 cents, less in quantity.

## *Health Costs*

The cost of modern prescription drugs presents a serious problem to families with low or moderate incomes, according to the Citizens' Committee for Children of New York City, which recently completed a study of family experience in obtaining such medicines.

Noting that the cost of prescription drugs has risen dramatically, especially of the antibiotics, which account for 40 cents of the dollar spent by the public for drugs, the committee reports that many families skimp on their food budget to pay for medicines and that some borrow from relatives to pay the druggist.

The committee calls on public departments of health and welfare to plan together to define the nature and extent of public responsibility for providing drugs needed by patients who cannot afford to pay for them and to join other health organizations in educating the public not to demand that physicians prescribe specific brand-name drugs. The committee also urges that medical schools, hospitals, other professional groups, and ethical pharmaceutical manufacturers accept responsibility for strengthening the physician's resistance to public demand for such drugs and for encouraging a more discriminating use of them. Again, it suggests that public and voluntary health agencies, health-insurance companies, and civic organizations work together to obtain support for changes in public policy that would help alleviate the problem.

Copies of the report are available from the committee, 112 East 19th Street, New York 3, N. Y., at $1.

## *ADC Study*

The stability of the findings of a study carried out during 1956-57 to determine the effectiveness of inservice training and of reduced workloads in the aid-to-dependent-children program is currently being tested in a joint project of the University of Michigan and the Michigan State Department of Social Welfare.

The original study sought to answer two questions: What can inservice training for ADC workers do to enable workers to render effective service to families? How does size of caseload affect the ability of ADC workers to render effective services, both with inservice training and without it? "Effective service to families" was defined as helping families move toward strengthened family life and increased self-maintenance.

The research approach was that of a field experiment, involving a program of inservice training put into effect in two Michigan counties and a reduction in the size of the workers' caseloads in these counties. In a second pair of counties, which were roughly comparable to the first pair, workers' caseloads were also reduced, but no inservice training was provided. A third pair of counties where neither training nor a reduction in workloads was provided was included in the study for control purposes. The research consisted of finding out what differences, if any, among the three groups of workers and among their clients could be attributed to training or to reduction of caseloads.

The major findings were:

(1) The workers who received training, when they were compared with those who received no training, showed a significant improvement in skill in identifying problems and in diagnosing the behavior of recipients. Furthermore, they showed superior ability in giving support and assurance to recipients during interviews.

(2) The families served by ADC workers with training showed a greater degree of improvement in certain aspects of family living than did families served by workers without training. Areas of improvement included housekeeping, development of individual resources, and an apparently enhanced sense of personal worth.

(3) The reduction of caseloads from 100 to 50 cases was followed by an increase in employment of ADC recipients or their family members, regardless of whether the workers received the inservice training program or not. In the counties where neither training nor reduced caseloads were provided, neither family life nor capacity for self-maintenance improved.

Edwin J. Thomas, director of the study, has cited a number of points to keep in mind in interpreting these findings, including: the period of inservice training was brief; and the time elapsed after the training program was completed was too short for all the results to show in the adjustment of ADC families.

The followup study, directed by Donna McLeod, is not only testing the stability of the first year's findings but seeking ways to adapt the experimental program to the practical requirements and limitations of a regular county welfare department. For instance, as a way of reducing the workload of ADC workers without a substantial increase in staff, many of the routine administrative activities of workers have been either simplified or transferred to clerical personnel. The result is more time for direct service to clients, which was the goal in the reduction of caseloads in the first year's experiment. Many other adaptations are being produced.

Pauline Bushey has served as director of training for both studies.

## *Integration*

Representatives of 32 national social agencies met in New York in June for a 1-day workshop on racial integration in social services sponsored by the Committee on Intergroup Relations of the National Social Welfare Assembly. The participants dealt with four aspects of integration: Personnel, program, finance, and planning.

National agencies, they agreed, could move forward, through their own normal democratic procedures, by taking the following steps: (1) Making a formal statement, or restatement, of the agencies' goals, objectives, and principles; (2) clarifying their own policies and practices in regard to their own meetings, their personnel, their staff and volunteer training programs, the membership of their national board and committees, their publications, and all publicity and public relations; (3) developing a step-by-step, long-term plan for advancement of inclusive programs; (4) providing for a periodic stocktaking; (5) carrying out research inquiries into such questions as: What happens to the constituents when a segregated unit integrates? (6) convening group consultations at the regional level; (7) being supportive of local constituents.

National agencies can assist their local affiliates, they suggested, by: (1) Using national board and committee members locally as appropriate; (2) providing regular staff consultation; (3) encouraging the affiliates to (a) examine their own charters and state their policies and goals, (b) carefully plan their program and time schedule, (c) employ qualified integrated staff on merit basis, (d) help the community toward integration, taking the initiative if necessary and supporting other agencies in their community leadership.

Throughout the day's discussion, the participants stressed the importance of maintaining the focus on what is happening to people. They also called for tailoring planning in regard to any local situation to knowledge of specific circumstances. They suggested that in instances of local tension, national agencies might meet together to discuss the local problem and the help each might contribute toward an easing of tensions.

A report on the workshop will be available this fall from the National Social Welfare Assembly, 345 East 46th Street, New York 17, N. Y.

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To help schools to provide a satisfying learning experience for the children of all groups in a neighborhood of mixed ethnic and economic characteristics, the Bank Street College of Education, New York City, and the city's board of education are conducting a 2-year pilot project that includes collaborating with interested teachers, classroom work with children, and encouraging parents to support the school program.

The project, financed by the New York Foundation, the New York Fund for Children, and the board of education, is being carried on in an area, until recently predominately white middle class in character, into which Negroes and Puerto Ricans of meager economic means have been moving in increasing numbers; where the schools are marked by much academic retardation, high turnover among both pupils and teachers, little participation in school affairs by the majority of parents; and where many children and parents do not speak English.

The project's staff consists of a director and a field coordinator, who are members of the college faculty, and four teacher-consultants—1 full-time, 3 part-time—assigned by the board of education.

Efforts to build up parent interest and participation in the school program have included visits to the home of every child; the organization of mothers' clubs; the issuance of a new bulletin for parents, written in Spanish and English; development of a sustained parent-education program in the schools; and the organization of a parent-planning group concerned with both school and community improvements.

Among the staff's school activities are: Working with teachers and parents to help 5-year-olds adjust when entering kindergarten; carrying on dramatizations, map studies, and discussion groups with the children to help the teachers see their capacities; introducing visual aids and other special materials into the schools; and offering a course for teachers on resources for teaching social studies, aimed in part to deepen the teachers' understanding of the community.

## *Radiation*

A joint committee on health of the school child, representing three operating units of the Department of Health, Education, and Welfare, recently recommended consideration of the tuberculin skin test as the initial means of detecting tuberculosis among school children and school employees—two groups among whom the incidence of the disease is, on the whole, low. If skin tests are given, the committee pointed out, only persons whose test results are positive need be given chest X-rays.

In view of the comparatively few new

cases of tuberculosis found through X-ray programs and of the possible harmful effects of periodic exposure to low-level radiation, the committee urged State and local education authorities to seek changes in laws and regulations that now make periodic chest X-ray examinations compulsory. Such changes, the committee said, would pave the way for application of new knowledge and techniques in tuberculosis case finding.

In the light of changing conditions, the committee noted, the value of mass X-ray programs should be weighed against costs and radiation exposure. However, it advised education officials to seek professional advice and assistance from State or local health authorities before making any changes in case-finding programs.

The committee also recommended that where X-ray programs are conducted the equipment be inspected at regular intervals and that adequate safeguards be used to protect all persons involved from unnecessary radiation.

Some months ago the Public Health Service recommended as a general policy that X-ray surveys be conducted on a selective basis rather than on a mass or communitywide basis.

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Radioactivity in all the milk samples examined by the Public Health Service in five geographic areas during a recently completed 1-year pilot study was found to be well below the amount considered "permissible" by the National Committee on Radiation Protection and Measurement. The study, which is continuing, was made in the milksheds serving Sacramento, Calif.; Salt Lake City, Utah; St. Louis, Mo.; Cincinnati, Ohio; and New York City.

Milk samples were analyzed for specific radioisotopes, including strontium-90, which is taken up by the bones when it enters the body. The amounts of strontium-90 in the milk ranged from 5 percent of the permissible concentration to somewhat less than 10 percent. Much lower percentages of two other radioactive elements—barium-140 and cesium-137—were found.

The study is part of the Public Health Service's broad program of environmental analysis, which measures amounts of radioactivity in water, air, and food. Through the study the Service is developing improved sampling methods and analytical techniques so that State and municipal health agencies and the dairy industry can eventually do their own analyses.

Additional sampling points are being established in milksheds serving six States.

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New York City recently amended its sanitary code to protect the public against radiologic hazards from X-ray machines and similar equipment. Under the new rules, which became effective June 15, 1958, all installations where radiation is produced, used, operated, or stored must be registered every 2 years with the city department of health, with information regarding the radiation sources and the name of the person responsible for the use of the equipment. Only persons licensed to practice medicine, dentistry, podiatry, or osteopathy, and persons supervised by those so licensed are permitted to apply radiation to a human body; and sale, lend, or lease of radiation equipment to anyone other than such persons or institutions supervised by them is prohibited. Other safety measures required include shielding radiation sources, reporting radiation accidents, instructing employees in radiation hazards.

## *Mental Retardation*

As part of a 4-year project to study mentally retarded children in four rural counties in Minnesota, begun late in 1957 by the State departments of health and welfare, dental conditions among retarded children will soon be compared with dental conditions among other children in the area. In a 2-week survey made during the past summer, interviews with the 44 dentists practicing in the 4 counties showed that all but 2 had treated extremely retarded children at some time, though some had treated very few.

Almost all the dentists stressed the importance of teaching parents that retarded children should be brought to a dentist before their teeth deteriorate so much that treatment is extra difficult for the dentist and hard on the child. The project's plans include: Giving a complete dental examination, including X-ray studies, for 110 of the 700 children who had been referred to the larger study by the end of July; a study of parents' attitudes toward dental care for their children through interviews and questionnaires; and a 1-day seminar for dentists on the treatment and care of retarded children's teeth. After analysis of the dental examinations decisions will be made on whether to give similar examinations to the other children. The seminar may be combined with a similar inservice training program for physicians.

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Four 3-week graduate courses for pediatricians, psychiatrists, and other physicians on the staffs of centers or institutions for mental retardates will be given during the academic year 1958–59, at Letchworth Village, a New York State school for mental defectives, with financial help from the National Institute of Mental Health. The first course will begin November 3. Further information may be obtained from the program director, graduate training division, Letchworth Village, Thiells, N. Y.

## *International Programs*

A 1959 World Health Organization program of increased assistance to health services and stimulation of research was unanimously approved by the Eleventh World Health Assembly, the governing body of WHO, at its 1958 annual session, held for 3 weeks in Minneapolis in May and June.

Delegates of 85 member nations of WHO, meeting for the first time in the United States, adopted a budget of $14,287,600 for the coming year—a 5-percent increase over the 1958 budget. In addition WHO is expected to expend $5 million of the United Nations technical-assistance funds.

Continuing the organization's orientation toward the strengthening of national public-health services, the Assembly authorized WHO to extend and intensify its efforts to eradicate malaria from the world; to study ways in which WHO can increase its stimulation and coordination of research in special diseases, including cancer and heart disease—for which the United States contributed a special fund of $300,000; to aid countries in the use of radioactive isotopes in medicine and to study the effect of radiation on human heredity and the relation between radiation and health in general; to take steps toward a global smallpox eradication program, to which the Soviet Union is contributing 25 million doses of vaccine; and to collaborate with the International Federation of Sports Medicine in making studies, including a study of the role of exercise and training in a health program.

The 1959 budget also calls for a general broadening of programs in relation to environmental sanitation, venereal diseases and treponematoses, endemo-epidemic diseases, public-health administration, nursing, maternal and child health, mental health, and nutrition.

The entire program will include about 800 projects in nearly every country and territory in the world.

At the close of the Assembly, WHO's executive board announced the selection of "Health Education of the Public" as the chief topic of discussion for the Twelfth World Health Assembly, to be held in Geneva in 1959.

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The International Children's Centre, Chateau de Longchamp, Bois de Boulogne, Paris, has recently set up a guidance service for professional personnel in the broad field of child health and welfare while traveling or studying in Europe.

Among the types of assistance the service provides are: Information; introductions; help in organizing work; and arrangements for visiting appropriate organizations and institutions.

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A new social-work quarterly, *International Social Work*, is being published as the official journal of the International Conference of Social Work and the International Association of Schools of Social Work. Among the items included in the first issue, dated January 1958, are the proceedings of the Eighth International Congress of Schools of Social Work and a report on the eleventh session of the United Nations Social Commission.

Subscription office: International Conference of Social Work, Room 1017, 345 East 46th Street, New York 17, N. Y. Price $4 a year.

## *Juvenile Delinquency*

In view of findings of its continuing study, begun in 1957, of State correctional schools for boys and girls, a report of the subcommittee on juvenile delinquency, of the Senate Committee on the Judiciary, recently made the following recommendations: (1) The establishment by the Federal Government and by each State, through universities and schools of social work, of training centers to develop staff for correctional institutions, especially cottage supervisors; (2) the establishment by every large community of "halfway houses"—residential centers for boys and girls released from State correctional institutions; (3) the more careful screening of staff for correctional institutions to make certain that they are emotionally stable and of good character; and (4) the increased development in institutions of special instruction for slow learners, especially retarded readers. (Senate Report No. 1429, 1958.)

## *Congressional Action*

The 85th Congress has appropriated $43,500,000 to the Children's Bureau for grants to States for maternal and child-health services, services for crippled children, and child-welfare services during the fiscal year ending June 30, 1959, an increase of $2,000,000 over the appropriation for the purpose for the previous fiscal year. The entire increase occurs in the appropriation for child-welfare services ($12,000,000), and it brings this fund up to the full amount authorized by the Social Security Act, as amended. Both the appropriation for maternal and child-health services ($16,500,000) and that for services for crippled children ($15,000,000) are equal to the amounts authorized. For Children's Bureau salaries and expenses the amount appropriated is $2,000,000, the same as for the previous fiscal year.

In addition the Congress appropriated $150,000 for necessary expenses in preparing for the 1960 White House Conference on Children and Youth. (Public Law 580, 85th Congress, approved Aug. 1, 1958.)

## *For Youth*

Sixty-five representatives of 22 Federal agencies came together for an all-day meeting in mid-June to discuss "the challenge to family, school, and community of teen-agers not succeeding in their present school programs." Sponsored by the Interdepartmental Committee on Children and Youth, the seminar focused on the reasons many adolescents fail to get along in school and on possible ways Federal agencies might contribute toward local efforts to help them.

The discussions emphasized the multiplicity of the problem's causes and effects. Among the causes brought out were: Lack of motivation of student by family and community cultural patterns; poor health; emotional instability; economic and environmental reasons; above or below average ability; inadequacy of the school program for meeting individual needs.

Among the effects stressed were the unhappiness and frustration which result in deviant behavior— and hence in problems for the family and community—and the employment difficulties confronting early school leavers because of poor preparation and child-labor law restrictions.

While recognizing that young people in both rural and urban areas suffer from difficulties in school, the participants identified differences between their problems. City schools, they said, are apt to have better equipment and services and more highly trained personnel, but may be so large that the student and his problem become lost in anonymity; while country schools, where teachers are apt to give more individual attention, are likely to be less well equipped with facilities, services, and highly trained personnel.

Rural youth who leave school, the participants also pointed out, face steadily shrinking employment opportunities in rural areas but in migrating to cities must compete for work with urban-schooled youth.

The participants agreed that early identification of students not achieving their potential in school is an essential first step for any program to keep young people in school. Such identification, they said, should be followed up by coordinated school and community resources for appropriate therapeutic attention.

Before adjourning, the participants requested further meetings on the subject.

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Many young people with social, educational, physical, or personality handicaps severe enough to stamp them in most eyes as "unemployable" can be usefully placed in industry, according to the experience of a specialized employment service operated by the University Settlement in New York City.

Established primarily for teen-agers who have dropped out of school, the service, called CONTACT, is available to boys and girls between 16 and 20 living in New York City's Lower East Side—most of whom are referred by churches, schools, social agencies, law-enforcement agencies, and individuals in the neighborhood.

Of more than 500 applicants in the first 5 months, one-fifth were unable to read or write well enough to do a delivery boy's job. Many were extremely hostile, immature, and unable to accept responsibility or to plan. With a staff of one trained worker and one volunteer, CONTACT succeeded in placing in jobs nearly two-thirds of the young people referred in this period.

CONTACT's service, now in its second year, is not restricted to job placement. It includes urging some applicants to return to school or to take vocational training, directing some toward community resources for intelligence, aptitude, or other tests or for social service; and referring a few for pyschiatric or other medical treatment.

The agency does not consider job placement successful until followup shows that the young person is adjusted to his new work. If not, the service gets in touch with him and encourages him to try again.

## *Miscellany*

Late in July the National Foundation for Infantile Paralysis announced a change in name to the National Foundation, and an expansion of its program to include attacks on congenital malformations and arthritis, in addition to continuation of its 10-year-old concern with poliomyelitis, other virus diseases, and disorders of the central nervous system. The chief focus will be on research, according to the announcement, but as in the past, the program will also include patient aid and professional education. The Foundation already has plans under way to provide care for patients under 19 years of age who have arthritis or treatable birth defects of the central nervous system, such as spina bifida (open spine), encephalocele (open skull), and hydrocephalus (water on the brain).

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*The Crippled Child*, which has been published bimonthly for the last 35 years by the National Society for Crippled Children and Adults, appeared for the last time in August 1958. Instead of the periodical, the society has begun to issue a new series of pamphlets for the parents of crippled children.

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A New York State law that becomes effective October 1, 1958, requires that in order to use the title, "psychologist," a person must hold a State certificate. The certificate will be granted only to persons who hold a doctorate in psychology, have had 2 years of experience, and pass a State examination. The law provides that reputable practicing psychologists who already have the degree and the required experience may become certified without taking the examination.

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# Guides and Reports

CURRENT SOCIAL RESEARCH; a selected inventory of research and demonstration projects in fields related to programs conducted or assisted by the Social Security Administration of the Department of Health, Education, and Welfare. Community Research Associates, 124 East 40th Street, New York 16, N. Y. 1957. 205 pp.

Describes 372 current research and demonstration projects on subjects related to welfare, health, rehabilitation, behavior, and socio-economic problems.

SOCIAL SCIENCE IN THE PROFESSIONAL EDUCATION OF SOCIAL WORKERS. Grace Longwell Coyle. Council on Social Work Education, 345 East 46th Street, New York 17, N. Y. 1957. 69 pp. $1.

Reports on a survey of the extent to which content from the fields of anthropology, sociology, social psychology, economics, and political science is introduced into the curricula of schools of social work and suggests ways of integrating such material with basic social-work theory in a program of education for social work.

DIRECTORY FOR EXCEPTIONAL CHILDREN; educational and training facilities. Third edition. Porter Sargent, 11 Beacon Street, Boston 8, Mass. 1958. 320 pp. $6.

Describes schools, homes, clinics, hospitals, and services for groups such as the socially maladjusted, the mentally retarded, the emotionally disturbed, the orthopedically handicapped, the cerebral palsied, the speech handicapped, the brain injured, the epileptic, the blind, and the deaf.

IDENTIFYING AND EDUCATING OUR GIFTED CHILDREN. George E. Hill, Rita J. Lauff, and John E. Young. Pupil Services Series No. 1. College of Education, Ohio University, Athens. 1957. 43 pp. $1.

A report on a study made in southeastern Ohio to determine the incidence of gifted children in the area, to evaluate methods of identifying such children, and to show some of their characteristics.

FINDING FOSTER HOMES; a report on the home-finding program of the Federation of Protestant Welfare Agencies, New York City. Cornelia M. Ougheltree. Child Welfare League of America, 345 East 46th Street, New York 17, N. Y. 1957. 24 pp. 50 cents.

Describes a 4-year experiment in developing a program for finding boarding homes needed by social agencies for Negro children.

NEW DIRECTIONS IN DELINQUENCY PREVENTION, 1947–57. New York City Youth Board. 1957. 39 pp. Copies available without charge from the Board, 79 Madison Avenue, New York 16, N. Y.

Reports on 10 years' experience of a city's program to reduce delinquency and shows the program's present status.

# READERS' EXCHANGE

### SCHULMAN: *A public responsibility?*

In her excellent report on the Conference on Family Casework in the Interest of Children, Rena Schulman points out, and quite rightly, that because of the "moving together" of various casework specialties in regard to children living in their own homes, the conference would have profited from participation by child-guidance and child-welfare workers. ("In the Interest of Children," by Rena Schulman, CHILDREN, July–August 1958.)

The conference statement is, of course, far ahead of current practice. To anyone working with cases of child neglect it becomes very evident that present-day social-service resources are only to a very limited degree available to families who are in the greatest need of help.

For this reason it was heartening to note that the conference candidly faced the identification of the family-service field with the well-motivated client from the middle and upper classes. It showed an awareness of that increasing group of marginal families who do not seek out a social agency but in whose homes childhood is often an incredibly oppressive experience.

Miss Schulman suggests that since both family-service and child-welfare workers are becoming increasingly concerned over the need to work with the total family—father, mother, and children—on the basis of individual and family evaluations, a more comprehensive coverage might be achieved if the family agency served as the "general practitioner" who makes the initial diagnosis and refers to the specialist those families which require more than the family agency can give.

However, since family agencies are usually privately financed, how could this ever be achieved? Would they have the resources to seek out that large group of families in which the plight of children requires community intervention? This reader believes that they have a definite obligation to give leadership, but would it not be more realistic to view the initial service—especially in cases of child neglect—as a public child-welfare responsibility? And if the need of the client is to determine the service given, wouldn't the public assumption of this responsibility hasten the day when the functions of the child-welfare worker are conceptualized as similar to those of the family-service worker?

*G. Lewis Penner*
*Executive Director, Juvenile Protective Association, Chicago.*

### *More conferences needed*

Rena Schulman's review of the report of the Conference on Family Casework in the Interest of Children should provoke some more definitive action on the part of those of us in child welfare who, for whatever reason and in spite of our experience and knowledge, continue to serve children in varied degrees of isolation from their families, to whom the children wish we would direct more of our interest and attention.

Social workers generally will endorse Miss Schulman's suggestion that the strengthening of basic social services will free the specialized services to carry out their functions more effectively. The need for skilled personnel and supporting services and resources, emphasized in both the report and the review, implies a joint responsibility of profession and community to continue efforts in the direction of identifying needs and initiating action to the end that parents may take joy in their parental roles.

Social workers in all settings will want to study the report of the conference, which should enrich social-work practice generally.

*Mary L. Buss*
*Director, Division of Child Welfare, State Department of Health and Welfare, Augusta, Maine.*

### BAYLEY: *Re infant tests*

Nancy Bayley's appraisal of the infant developmental tests is important and timely for several reasons. ("Value and Limitations of Infant Testing," by Nancy Bayley, CHILDREN, July-August 1958.) It presents the opinion of an experienced and competent investigator who knows of what she speaks because of long-range studies of developing infants and children.

However, despite Dr. Bayley's warnings about the unpredictability of infant tests given in 1933 and later, and similar warnings of a few other investigators, there continues to be misuse of the tests and misinterpretations of their results by investigators, clinicians, and lay persons. Concurrently with the publication of Dr. Bayley's last article there appeared one by the Ross Laboratories ("Physical and Behavioral Growth: 26th Report of the Ross Pediatric Research Conferences, 1958") in which a former associate of the Gesell group in New Haven categorically states: "Using the Gesell Developmental Examination as the testing tool, we have been able to predict accurately an infant's later intellectual behavior."

This kind of statement, like the confusing statements of Drs. Gesell and Amatruda on the predictive value of the developmental quotient as expressed in their book "Developmental Diagnosis" continues to feed the hope of adoptive parents and social agencies that later-life intelligence may be predicted early in life so that adoptive parents may be assured good products. Dr. Bayley's article clarifies the words of Drs. Gesell and Amatruda on the uses of infant tests prognostically, and presents a clearly defined, multidimensional description of the meaning of intelligence and its determinants.

I hope Dr. Bayley's latest evaluation of infant tests will be widely read not only by social agencies, physicians, and laymen, but also by professional psychologists who carry out infant testing and use the results predictively.

*Milton J. E. Senn, M. D.*
*Director, Yale University Child Study Center, New Haven, Conn.*

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# SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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1957 ANNUAL REPORT. Department of Health, Education, and Welfare. 1958. 263 pp. 75 cents.

This report for the fiscal year ended June 30, 1957, includes information on the activities of the Secretary's office, the Social Security Administration, Public Health Service, Office of Education, Food and Drug Administration, Office of Vocational Rehabilitation, Saint Elizabeths Hospital, American Printing House for the Blind, Gallaudet College, and Howard University.

CRIPPLED CHILDREN'S PROGRAM: a statistical review for 1956. Sadie Saffian. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 44. 1958. 23 pp. Single copies available from the Bureau without charge.

The number of children receiving physicians' care under the State-Federal crippled children's program increased 38 percent between 1950 and 1956 in comparison with a 19 percent increase in the population as a whole, according to this report. In that same period, the report says, the number of children with nonorthopedic conditions receiving care—such as epilepsy and eye conditions—increased by 61 percent while the number of those with orthopedic conditions increased by only about 22 percent. An appendix table shows for each State the number of children with specified diagnoses, classified as orthopedic and nonorthopedic.

TRENDS. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 367. 1958. 11 pp. Single copies available from the Bureau without charge.

Includes 1940 statistics on child welfare, including public child-welfare services, adoptions, and juvenile-court cases of delinquency and of dependency and neglect; and on public services for crippled children and for maternal and child health. Presents also, in graphic form, statistics on children receiving child-welfare casework services from State and local public agencies, 1946–57; statistics on juvenile-court delinquency cases, 1940–56; on children served under the public crippled children's program, 1937–56; and on infants, preschool children, and mothers receiving selected maternal and child-health services, 1937–56.

RESEARCH RELATING TO CHILDREN, reported August 1, 1957–February 28, 1958. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. Clearinghouse for Research in Child Life. Bulletin No. 7. 1958. 147 pp. $1.

This issue of the Clearinghouse bulletin on ongoing research in fields concerning children continues the series of reports on research programs in physical and motor development; intelligence, behavior, and personality; education; health services, and social services. Included for the first time is a list of other abstracting journals and services.

COOPERATIVE RESEARCH PROJECTS, FISCAL YEAR 1957. Romaine P. Mackie, Harold M. Williams, and Alice Yeomans Scates. Introduction by Herbert S. Conrad. Department of Health, Education, and Welfare, Office of Education. 1958. 63 pp. 25 cents.

Presents a brief description of the Office of Education's cooperative research program and of the research projects begun in cooperation with universities and colleges and State educational agencies during the fiscal year ended June 30, 1957.

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**Notes on Evaluative Research**

**Feeding the Chronically Ill**

**Sources of Parent Behavior**

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WHEN MOTHER IS AWAY a homemaker sent in by a social or health agency can keep the rest of the family together in surroundings that are securely familiar. (See pages 210–212.) The homemaker here came from the Maricopa County Temporary Child Care Service—a service of the Arizona Department of Public Welfare—to care for the five children in the picture while their mother was away in a hospital.

## ◀ *the authors*

Before coming to the Children's Bureau in 1954, Elizabeth Herzog was director of research for the Jewish Family Service in New York. Previously she worked at Columbia University on a project in cultural anthropology Research in Contemporary Cultures. She is author or co-author of several books and has also written numerous articles in professional journals on the application of scientific methods to the research needs of social casework. During the war she conducted opinion and attitude research for the Office of War Information.

Joseph H. Reid joined the staff of the Child Welfare League of America in 1950 and has been its director since 1953. With experience in both private and public social agencies he is currently on the executive committee of the National Social Welfare Assembly. Before joining the League's staff he was with the Ryther Center at Seattle. He received his master's degree in social service from the University of Washington.

Dr. Pauline Stitt has twice before appeared as an author in CHILDREN—first in November–December 1955 with an article on inter-agency communication and again in March–April 1956 as a collaborating author with nutritionist Bertha S. Burke on nutrition services for crippled children. Once a medical director for the Children's Bureau in the Atlanta Region (1945–46), Dr. Stitt has been director of maternal and child health and crippled children's services in Hawaii and assistant director of the Alameda County Health Department in California.

Orville Brim developed the ideas in his article as part of an inquiry into the assumptions of parent education he is currently engaged in. Other facets of the subject on which he has so far reported are: the effects of the parent on the child; and the competence of parents. When the project is completed the full report will be published in book form. Another publication of his, now in press, is a monograph of the Society for Research in Child Development on basic research problems in parent education. From 1952 to 1955 Dr. Brim was assistant professor of sociology at the University of Wisconsin.

The necessity of moving from place to place for a number of years to keep up with a Marine Corps husband has resulted in Jane McFerran's gaining child-welfare experience in agencies in New York City, Austin, Tex., Portland, Oreg., Wilmington, N. C., and Inglewood, Calif. After settling down in Louisville she at first worked in adoption with the Louisville and Jefferson County Children's Home, but has been in her present position since 1954. She is a graduate of the University of Texas and of the New York School of Social Work, Columbia University.

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*Some notes on evaluative research . . .*

# HOW MUCH ARE THEY HELPED?

ELIZABETH HERZOG
*Assistant Chief, Technical Studies Branch, Division of Research, Children's Bureau*

ONE OF THE MOST difficult—and most desired—types of evaluative research has to do with determining the effectiveness of efforts to bring about social or emotional change in individuals. A number of therapies and services are directed toward such change—for example, psychotherapy, social casework, groupwork, services to prevent juvenile delinquency and to treat delinquents, and certain aspects of parent and family-life education.

Efforts to bring about psychosocial change in individuals are directed toward helping them deal with difficulties in social and psychological functioning. Efforts to evaluate ask: have the individuals been helped? This key question, however, is a very unstable compound. Under examination it breaks down into a cluster of questions: which ones have been helped? how much? how stable is the help? was it really the treatment or something else that helped? who says so? and how do we know it is true?

Such questions are challenging enough when raised about the effectiveness of a single practitioner. When the reports of many practitioners or agencies are combined or compared, a different kind of question is added: Were they all defining help in the same way? Did they all begin with problems of the same or comparable difficulty? Were the individuals they worked with equally capable of change? Were the improvements noted comparable in kind or degree or stability?

The history of evaluative research shows increasing recognition of the questions that must be answered, increasing awareness that they cannot be answered quickly or simultaneously, and increasing efforts to lay the groundwork for defining them, setting priorities for them and attacking them in due order. The present discussion concerns only research assessing the effectiveness of efforts to bring about social and emotional change in individuals. However, some of the principles involved would apply to any evaluative research.

A review of the literature, reinforced by discussions with research people, shows a rather neat grouping of points on which the "experts" do and do not agree. They agree on the need for evaluative research, on the complexity of the problems it presents, and on the fact that so far no one has solved these manifold problems to the complete satisfaction of himself or anyone else. They agree also that even before its problems are solved, great values are to be gained from the right kind of evaluative research. Some of these values lie in its results, some in the gains derived from the process itself.

On the whole, the experts agree also about the questions that ought to be answered in any sound evaluative study. The individual researcher does not always answer each one of these questions himself, nor is it always possible to do so. But on being asked, trained and experienced research people are very likely to concede that these are the questions which *should* be answered. They tend to disagree about the best means of answering them and about what constitutes an adequate answer.

## *The Questions*

It is generally agreed that a satisfactory evaluation of efforts to bring about psychosocial change in

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Based on a chapter from a forthcoming publication, "Some Guide Lines to Evaluative Research," Children's Bureau.

individuals should deal directly with the following questions:

I. About the study: What is the purpose of the evaluation? (What is to be achieved by doing it?)

II. About the efforts that are to be evaluated: (a) What kind of change is desired? (From what and to what? Known by what signs? In whom?) (b) By what means is change to be brought about? (What method is used—in theory? What method is used—in practice? By whom is the method used?)

III. About the methods used for assessing change: (a) How trustworthy are the categories and measures employed? (How reliable are they? How valid are they?) (b) At what points is change measured? (From what base? After what interval?) (c) How fairly do the individuals studied represent the group discussed? How is the sample selected and defined?) (d) What is the evidence that the changes observed are due to the means employed? (What controls, if any, are used?)

IV. About the findings: (a) What is the meaning of the changes found? (How satisfactory?) (b) Were there unexpected consequences? (Of means employed? Of research or researcher?)

To different degrees and in different ways, these questions are interrelated. Some interlock so closely that it is impossible to consider one without simultaneously considering the other. Some depend on each other in such a way that the second cannot be raised until the first has been settled. Moreover, they are questions of different kinds. Those in group III are primarily the responsibility of the researcher. He cannot even pose the questions clearly, however, until he has answers to groups I and II, which are primarily the responsibility of the practice field as represented by the agency of organization that initiates the research. To say that the first two groups of questions are primarily the responsibility of the field, however, is not to imply that they can be answered by the practitioner alone—unless he is also a researcher—for the answers must be in terms that lend themselves to research.

To the best of our knowledge, no study has ever fully answered all of these questions. Merely stating them defines a dilemma between what is wanted and what can be delivered.

One view of this dilemma is suggested by three terms applicable to three kinds of evaluative research:

1. ***Ultimate evaluation*** refers to the kind of evaluation that everyone wants most. The practitioner, the public, the administrative official, the supporting contributor, all want evidence now of the degree to which the practice or service under examination helps the people it serves. With regard to psychotherapy, they want to know the effectiveness of psychotherapy in general or of a particular school of psychotherapy. Similarly, those working with juvenile delinquents want to know, for example, the effectiveness of probationary services and the relative effectiveness of different types of probation. Or they may want the answer to analogous questions about training schools or preventive measures.

Unfortunately, research cannot produce here and now the *ultimate evaluation* of efforts to bring about psychosocial change in individuals. And probably the evaluative questions will need to be reformulated and sharpened if "ultimate" answers are ever to be secured. To discuss the effectiveness of psychotherapy in general, for example, may prove to be as unfruitful as discussing the effectiveness of surgery in general.

2. ***Pre-evaluative research*** refers to the kind of studies that will be necessary to answer the questions that must be faced before fully satisfactory evaluative studies can be made. Pre-evaluative research will be needed on most of the questions listed before ultimate evaluation will be feasible—questions about what change is to be produced, in whom, by what means, by whom, and the like.

Such research will contribute to practice as well as to ultimate evaluation. It will contribute also to reformulating our ideas about what is desired from ultimate evaluation. As diagnostic classifications and treatment goals and methods are more sharply defined, for example, the focus of the evaluative question is likely to be sharpened so that we may no longer be asking how effective is psychotherapy or social casework in general, but, rather, how effective is such-and-such a kind of treatment in producing such-and-such changes in such-and-such kinds of people.

3. ***Short-term evaluation*** means research that can be accomplished within a few years. Such research is possible and useful here and now. It is possible without extensive pre-evaluative research to give

properly qualified answers to properly qualified questions about the effectiveness of treatment or service by a specific agency or individual, with a specified population. Properly qualified answers would state clearly the limitations of the methods employed, observe the rules of evidence, make no generalizations beyond the limits of the data.

Short-term evaluation can often be done in a way that meets research requirements, fills immediate need, and at the same time contributes to pre-evaluative research. It cannot, however, give the answers that many people want most. These require evaluation, which in turn demands many pre-evaluative studies.

Apparently evaluative research assessing social or emotional change is at an interesting crossroad where it seems necessary to proceed in *both* directions at once. Fortunately, there are enough travelers to deploy forces along both routes. It is necessary to conduct pre-evaluative research in the effort to come nearer to the long-term goal of ultimate evaluation—recognizing that this goal may have changed its outlines somewhat before we finally reach it. It is also necessary to do whatever can be done with more approximate and less complete efforts at short-term evaluation, as background to immediate steps and decisions. Whatever type of evaluative or pre-evaluative research is undertaken can contribute to the other type—if and only if it observes the rules of evidence, explicitness, and restraint that are binding on any research.

Some practical implications of these points can be summarized under a number of "do's" and "don'ts" for evaluative research.

## *Some Research "Don'ts"*

***Don't undertake evaluative research if the purpose can be served by some other kind.*** It is expensive, time-consuming, difficult, and not always successful. If the purpose is to contribute to professional knowledge and understanding, a pre-evaluative study is likely to be more directly rewarding. If an evaluative answer is urgently needed, the answer can often be secured—or approximated—by quicker, more feasible and less costly types of research, such as factfinding or survey studies. Accordingly, short-term evaluation should be undertaken only if thorough consideration of the purpose shows no other feasible way of proceeding.

For example, a proposal was made to evaluate an ambitious program of individual treatment at a training school for boys. A simple survey revealed, however, that the current staff lacked the qualifications necessary to carry out the program as formulated, and in addition labored under a time schedule which precluded giving the boys any but the most superficial, perfunctory, and unindividualized attention. In this instance, analysis of actual operations, as compared with stated objectives, showed that there would be small gain in carrying forward an elaborate "evaluation" of a program not yet operative.

***Don't undertake evaluative research unless adequate resources are available.*** Adequate resources include money, staff, and time, with assurance of continuity since interruptions can be wasteful and also harmful to final results.

The question is often raised, can adequate research be done in an organization that does not have a full-blown research department? To this the most straightforward answer is that full-blown research requires full-blown research people. It is usually a mistake to think that satisfactory research—evaluative or otherwise—can be done by a practicing staff under the guidance of a part-time research consultant. The demands are too heavy. Any substantial research project requires full-time research staff plus full collaboration from practitioners.

Agency administrators who undertake research are often unprepared for the amount of practitioners' time required by a research project—the more able the research staff, the more consultation they are likely to want from the practitioners. The canny administrator will count such time as part of his research budget and will not attempt to add a research project, department, or worker without making due allowance either by increasing the number of practitioners or decreasing the number of their cases during the time they are involved in research. For example, the report of a study of short-term cases says that preparation of schedules and instructions took many months of discussion and tryout by the planning committee—including highly trained caseworkers; and that, once the study was under way, the administration allowed participating staff members 20 to 30 minutes after each interview to fill out schedules, cutting down their caseloads accordingly during the time of the study.[1]

Administrators are probably less surprised than they used to be at the length of time that elapses before a research project is completed. It may, for example, take 6 months to track down the subjects for a modest followup study. If tape recording is used, the requirements in time and money approach the fabulous. Carl Rogers has reported that the transcription of one 40-interview case filled over 300 single-spaced typed pages.[2]

***Don't count on using existing agency records as the sole source of data for an evaluative study.*** Case records make such interesting and instructive reading that it is hard to believe they would not furnish a satisfactory basis for evaluative research. Yet again and again investigators find that they do not. The needed items of information are seldom included in every record. When present, they are seldom comparable in explicitness, detail, and documentation. Exorbitant amounts of time may be spent trying to discover the most elementary facts about a case. If relatively recent records are used there may be serious problems in making them available for analysis—especially if closed cases are reopened by reapplication for service. All this is highly regrettable. Yet, on the basis of experience to date, most researchers prefer if possible to work out recording forms and procedures in advance. If this is not possible, it usually becomes necessary to supplement existing records with other sources of information.

***Don't indulge in lopsided research.*** It does not pay to lavish time and money on being precise in one feature if this is out of proportion with the precision of the rest. For example, it profits little to go to extreme lengths in insuring sample and reliability, if criteria are fuzzy and definitions ambiguous. This type of imbalance often tempts the researcher to imply in his report that the whole study is impeccable because of the good sample and reliability—forgetting that "no study can be better than its criteria." Part of the secret of appropriateness and harmony in design and pretensions is the recognition that research offers not one model but many models and that the plan must depend on the purpose.

***Don't be afraid of unpretentious research.*** Better be simple, clear, and forthright about limitations than to dress up crude or fuzzy data in fancy techniques. The value of frank opinion material is not to be minimized in connection with short-term evaluative studies. If therapist, patient, collaterals, and record analyst agree that certain types of clearly specified change have taken place the evidence is not to be belittled, even though it is drawn from material that cannot accurately be described as "objective."

This point is brought out by Brewster Smith in discussing the evaluation of the exchange-of-persons program—with a reminder of the close relation between purpose and method. "When evaluation is primarily for the benefit of the program's own administrators, skilled judgment may be substituted for proof at various points in the ideal pattern of evaluation, with great saving in cost and feasibility. The ideal requirements remain a useful reminder of the points at which judgment is being substituted for evidence; they indicate where cautious interpretation is likely to be in order."[3]

***Don't be confused by loosely used terms***—such as reliability, objectivity, statistical significance. Such terms represent important research elements. But if consumers—and researchers too—were more clear about what these words really mean, they would be less likely to assume that reliability insures validity, that counting insures objectivity, and that statistical significance insures signficance of content.[4, 5]

## *Some Research "Do's"*

***Do bring the researcher in early enough and fully enough.*** A chronic menace to sound and useful research is tardiness in enlisting the research director. It is not enough for him to be in on the ground floor. He must help to dig the ground and lay the foundation. This means that he must help to investigate the need for the proposed study, to formulate the purpose and to determine whether it can be served by the type of study proposed, or by any feasible research.

***Do include "intellectually hospitable" research specialists and practitioners on the research team.*** This requirement is often taken for granted but its full meaning is seldom recognized in advance. Successful interdisciplinary research requires: (1) selection of persons qualified for it by training, experience, and temperament; (2) allowance for sufficient practitioner time; (3) readiness to cope with the classic problems of interdisciplinary research which competence and experience can mitigate but cannot obviate. These problems have been discussed in many publications, but it often seems as if they need to be lived with before they are fully understood.[6, 7, 8]

***Do appreciate the rewards to be gained through pre-evaluative research.*** Many instances could be cited of researchers turning from evaluative to pre-evaluative projects because they became convinced (a) that the most satisfactory kind of evaluation could be done only after an extensive and intensive tooling-up period and (b) that, other things being equal (though usually they are not), pre-evaluative research offers a more direct contribution to better professional practice and to better understanding of people.

Many of the researchers interviewed and the theoretical articles reviewed in surveying evaluative efforts emphasized the need to know more about just what we are doing before we try to say just how well we are doing it; and not one favored trying to find out "how well" before doing more work on "what." This means, on the one hand, attempts to perceive and describe the significant factors in the problems treated, the individuals treated, the methods used, the therapist as an individual, the treatment process. On the other hand it means that an effort will be made to describe "change" rather than "improvement" or "deterioration". That is, to tell *what* change occurs before trying to rate its desirability.[2, 9, 10]

A good deal more pre-evaluative research has been done in psychotherapy than in social casework—research on diagnostic categories, on treatment process, on patient and therapist variables related to treatment outcome, etc. But as more serious and more large-scale research efforts are getting under way in social casework, the number of pre-evaluative projects seems to increase.

Research in other areas would also profit greatly by more emphasis on pre-evaluative research. Efforts to review evaluative research in juvenile delinquency, for example, have suffered from the unreliability and incomparability of the results of studies that fail to meet elementary research requirements. This failure is due at least in part to lack of sufficient pre-evaluative research. In this area as in many others, the most promising efforts seem to be veering toward filling the pre-evaluative gaps—such as the lack of adequate classification for the many kinds of behavior problems lumped under the term "juvenile delinquency." [11]

There is room for a great deal more pre-evaluative research in juvenile delinquency. It may be suspected that simple survey research on the treatment of juvenile delinquents throughout the country would be more effective, less costly, and less time consuming than abortive attempts at evaluation.

Pre-evaluative research sometimes—though by no means always—offers an immediate evaluative by-product. Its direct products, however, are valuable enough in themselves. Improved diagnostic classifications, improved descriptions and definitions of therapeutic methods are needed and wanted for practice as well as for research. Examination and analysis of practice are useful not only to the administrator but also to the practitioner. Testimonials to the helpfulness of a research look at practice are a familiar part of research reports. Ralph Kolodny has written in some detail of the practical gains an agency reaps through the research process, listing some concrete effects "which even the procedure of simply 'thinking in research terms' can have upon the day-to-day practice of a groupwork agency." [12]

***Do appreciate the value of coordinated efforts.*** The questions that press for answer are far too vast and complex to yield to the efforts of a single research project or organization. Until recently the kind of research under discussion here has tended to be piecemeal and to exist as if in a vacuum. Increasing efforts are being made to build on what has been learned from previous research, to test out research instruments by using them in new settings or in followup studies, to test out findings by duplicating studies or by repeating followup studies after a period of years.

This kind of interrelation between research projects represents coordination through time. Somewhat less frequent but no less desirable is coordination through space—between agencies or individuals, working on parts of one project or simultaneously undertaking similar projects in different places.

The promise of new types of research coordination is apparent in the current plans and directions of several national organizations, such as the United Community Funds and Councils, the Child Welfare League of America, and the Family Service Association of America. Such organizations, each with a research department in its national office as well as in a number of local affiliates, are in a position to pioneer, drawing on material from constituent agencies, some of which may not have their own research departments.

***Do appreciate the value of the research prerequisites: systematic study and exploration.*** Pre-evaluative research itself has important prerequisites, namely, exploration and clarification of terms, processes, and concepts, based on review of actual cases. This kind of exploration can be begun by small agencies and by individuals working alone, with great value for research and for practice. The results of their work can then be utilized and tested in more rigorous research undertakings.

Genevieve Carter points out that "concept clarification is one of the important outcomes of all social-work research," adding that while it can be the objective of a large research project it can also be undertaken by individuals working alone.[13] She cites as examples articles that evolve an "operational definition" of the term under discussion (e. g., "supportive treatment") by analyzing concrete examples from actual cases. She also points out the beneficent cycle represented by such study, since "research clarifies concepts and . . . clarification of concepts makes research possible."

Systematic case review for other purposes also offers great value for both research and practice, and lies within the scope of the small agency or the individual working alone. It is possible, for example, to single out for analysis one type of case—say, short-term cases, or cases concerned with one type of problem, or cases in which two family members are treated by two different practitioners—and by systematic examination to identify elements and characteristics not previously recognized or comprehended. To study one kind of case has much the value of a one-man exhibit of paintings by an artist whose work was seen previously only as part of large and heterogeneous showings. Characteristics and interrelations emerge that were not recognized before. These may be characteristics of cases or characteristics of treatment. For, as already noted, actual practice does not always conform precisely to the administrator's or the practitioner's conception of what is being done, and sometimes what seems to be a case characteristic turns out to be a result of the way a certain kind of person is treated.

Many other kinds of systematic study are possible, depending on the problems of most immediate interest to the agency. Although the examples mentioned come from social casework, the same kind of study can be fruitful for any agency or service attempting to bring about psychosocial change in individuals. For example, many of the pre-evaluative questions that haunt researchers in relation to juvenile delinquency can be approached by a modest exploratory case review, laying the basis for further steps toward getting an answer.

In other words, concepts can be clarified, definitions can be made explicit, characteristics of case types can be brought out without elaborate research procedures. One does not need an ambitious project in order to begin evolving needed research tools. Systematic study, without ambitious methods or pretensions, can contribute to the general reservoir that must be built up before "ultimate evaluation" can be achieved. To do well what lies within available resources will contribute far more to the agency and to the field than to do badly what requires time, money, and staff beyond the available resources. Obviously, in such investigations the conclusion and interpretation must be limited by the nature of the investigation. Such studies will not answer the pre-evaluative questions, but they will help evolve the tools required for answering them.

### *Claims and Expectations*

One frequently cited aim of psychotherapy—and also of social casework—is to help individuals attain the "need-free perceptions" that are part of mental health; [14] that is, to help them achieve a sturdy realism capable of perceiving, without distortion or evasion, the situations and problems that confront them.

Evaluative research of the kind under discussion urgently requires need-free perceptions on the part of those who carry out research, those who request it, and those who use its results. Such research at times has been plagued by unrealistic expectations on the part of research consumers and research producers. As the magnitude and complexity of the problems become evident, these expectations often give way to disappointment on one side and defensiveness on the other. One means toward realism in the research producer is familiarity with the material to be investigated. One means toward realism in the research consumer is understanding of the research problems involved. It is necessary to recognize on the one hand the difficulty and distance of the ultimate evaluation goal, and on the other hand the richness of the rewards to be achieved in approaching it.

A healthy realism is required not only concerning research goals and potentials but also concerning the purposes of those who use research and those who produce it. The administrators and boards who ask for a study must be clear whether their primary objective is short- or long-term evaluation. If the primary purpose is to advance professional knowledge, then pre-evaluative research is the best investment. If the primary aim is administrative, then there may be sound reason for short-term evaluation—but the primacy of this aim should be recognized and avowed.

On the other hand, the producer of research needs a healthy realism concerning the nature and values of what for convenience has been dubbed "administrative research." Research designed to help administrators serve people better hardly deserves the implication that it is inferior to other types of research, though it may be less gratifying to the researcher.

There is need to be on guard against a number of confusions, including the confusion of realizable research values with the status values that have grown up around certain types of research, and the confusion of need for a certain type of research with the need to make "an attractive package" that will get financial support. Need-free perception does not demand ignoring any of these values, but it does require recognizing which is which.

It would seem, then, that a major objective in research, as in the treatments, services, and programs research is asked to evaluate, must be honest, enlightened, and outspoken realism based on understanding of the materials to be investigated, the questions to be answered, the limitations to be recognized, and the rules of evidence to be respected in interpreting results.

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**Man is going to have to learn to live comfortably and effectively no matter how quickly changes take place in his immediate surroundings. That means that we are probably going to have to be very much more careful than we have ever been in the past not to give our small children absolute rules in childhood which may not be applicable when they are grown up. It may be that their world will be very different indeed from the world we can see now, and it may not be at all useful to them and to the world in which they live, if we impose limiting loyalties on them, if we give them the idea, for instance, that they should concern themselves only with local welfare, or that their concern should stop at national boundaries.**

***Brock Chisholm*, M. D., in World Health, *January–February 1958*.**

# HOMEMAKER SERVICE FOR CHILDREN

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COMMUNITY PLANNING for child care is filled with absurdities. Nowhere is this more apparent than in the fact that as much as $2,400 a year is frequently spent in caring for a child away from home for whom $500 spent on homemaker service would have been more appropriate.

Practices as wasteful and dangerous as this take place today, in spite of the chronic shortage of money for meeting children's needs and in spite of what is known of the emotional dangers of uprooting a child from his own home, because communities remain unconvinced of the importance of providing all the resources needed for children's welfare and because many child-caring agencies themselves have not raised their sights from narrow, inherited functions.

Fortunately this latter obstacle shows signs of gradually crumbling. While homemaker service is hardly beyond the experimental stage either in scope or method, persons and agencies concerned with services to children have expressed enough interest in it for inquiry into standards for homemaker service to become a natural part of the current National Standards Project of the Child Welfare League of America.

The very existence of homemaker service is in fact basic to good standards in other services for children. In most instances in which a family applies for help with child care because of the absence of the mother from the home, homemaker service should be the first service to be considered, not the last.[1] Too often its unavailability puts it out of the picture altogether. Although the volume of homemaker service has almost doubled in the United States in recent years, it is still virtually an unknown service in most communities.[2] By an historical accident institutional care and foster-family placement are still widely regarded as the ways to serve children who are temporarily deprived of maternal care in the United States.

By contrast, Finland, a country of only 4,200,000 people has over 1,000 trained homemakers in full-time service—as many homemakers as this country has to serve a population 40 times as large. What is more, these Finnish homemakers are on the whole better trained, each having had a minimum of 1 year of formal training, including supervised field service. Since many other countries of Europe have programs similar to Finland's, the idea of providing homemaker services on an extensive basis does not seem to be visionary.

In this country a consciousness of the potentialities of homemaker services has been slowly emerging over the past two decades. It can in a large part be attributed to the persistence of the National Committee on Homemaker Services. To be effective, however, it has to be backed by a similar awareness on the part of the public, which after all must furnish the necessary funds, either through taxes or voluntary giving. Social agencies must shoulder the major burden of creating this awareness by getting across to the public the importance of maternal care to a growing child, the dangers of separating a child from his parents, the wastefulness in money expenditure and psychological damage of avoidable foster care. Only after the public has become conscious of the existence of homemaker service as a basic standard for a child-welfare program can it be expected to become concerned with the more technical considerations of ways in which it should be provided.

## *A Major Service*

While the lag in this country in the provision of homemaker service is indeed regrettable, it is at the same time fortunate that homemaker service has not been "oversold." So far nothing that I have been able to find in the literature treats homemaker service as a panacea, and this, I think, is all to the good. However, I also believe that one of the reasons that homemaker service remains overshadowed by other no more basic services is the frequent reference to it as a tool—an auxiliary to family casework.

If it is to reach all those who need it, homemaker service must be offered as a basic social service with the use of casework help to the extent to which it is needed—to determine whether homemaker service is most suitable for the family, to help the parents and children with any problems they face in making the best use of the service, and to help with any problems that emerge and for which they want and can use the help of the caseworker. It is a mistake to offer it only to a family already engaged in some form of casework relationship. As a children's service, homemaker service must be viewed as one of the several needed in a community for families where the parents are faced with problems that call for help in carrying out the tasks of child rearing.

While adequate appraisal or diagnosis of the family's and the child's needs is essential for determining whether or not homemaker service will help, this is quite different from requiring a family to be engaged in a continuing casework relationship. There should be no such mandates for homemaker service nor, in fact, for several other kinds of service, among them the provision of day care for children. If the public gets the idea—a possibility from some of the literature available on the subject—that in order to obtain a homemaker it is necessary to be involved in a continuing casework relationship, the service either will not be used, or will be obtained through auspices other than social agencies.

The Jewish Big Brothers Association in Los Angeles provides an illustration of an agency which is able to make effective use of a service without necessarily involving its recipients routinely in a casework relationship. This agency has as its primary services counseling boys in their own homes and providing a professional Big Brother service. The agency also operates a nonsectarian camp for emotionally disturbed children. When a parent applies for admission of a child to the camp he is seen by a caseworker who obtains an adequate social history and a diagnostic picture of the child and family. The agency does not require the family to agree to accepting continuing casework help if the child is to be admitted to the camp. However, through the families' experiences with the agency and the agency's practice of offering casework service to families needing help, the camp has become one of the major case-finding sources of the agency.

This practice has implications for the provision of homemaker service, which after all as a preventive service should be available to stable and unstable families, rich and poor, those accustomed to using casework agencies and those who are not.

**On February 11–12, 1959, 400 persons assembled in Chicago will turn their attention to stimulating the kind of interest in homemaker services called for in the accompanying article. They will be meeting as the National Conference on Homemaker Services, under the sponsorship of 26 national agencies and 8 units of the Department of Health, Education, and Welfare. Clark W. Blackburn, general director of the Family Service Association of America, is chairman of the conference.**

**Preparations for the conference, already well under way, include, among other activities, a nationwide study and a revised directory of homemaker services, the development of statements by 12 local study committees working on various aspects of homemaker service, and the preparation of descriptions of homemaker programs in 11 agencies.**

If homemaker service is to be available to all children who need it a great deal of money has to be won for it. This will require considerable thought on how that money can be secured from a public that may be skeptical about the need for a service so long missing from the resources for child welfare.

Some of the experience of agencies which have succeeded in obtaining funds for homemaker services should be analyzed and publicized. For example: How did the Children's Aid Society of New York obtain financing for such a service? How did the Chicago Home for the Friendless shift from an essentially institutional program to using a major part of its budget for homemaker service? How did the public-welfare agency in Hamilton County, Ohio, demonstrate to the county commissioners that money spent for a homemaker service would be money well spent?

Getting the money will require an emphasis on the practicality of a service that will not only serve people better, but will take fewer dollars and cents than many better known and less suitable services. Agency boards and staffs, as well as the public at large, will have to be convinced.

While occasionally it may be possible to persuade an agency whose function has become outmoded that it can serve the public better through offering homemaker service, the fact must be faced that most agencies feel they have too few dollars for the services they are already rendering. Family agencies need more, not less, money for marital counseling; and agencies providing foster-home and institutional care for the most part feel handicapped by too high caseloads, which are related to insufficient funds for the payment of foster parents and child-care workers and for other costs. Yet these agencies and the communities in which they exist must be convinced that new money must be raised in order to save money, and that in some cases funds ought to be diverted from old line services which are not as effective in protecting children as homemaker service.

While a variety of private resources can undoubtedly be tapped, tax funds must play the major part in expanding homemaker service in the United States. The key to real expansion lies in the public agencies, which in terms of volume of service in the United States are by far the most important social agencies.

The job of persuading agencies to undertake this service must be done, not by attack, but by education; not by saying that homemaker service will prevent foster care, but rather by saying that it is a complementary service to any agency giving foster care. The goal is the achievement of a day when any agency dealing with children and families regards homemaker service as a resource essential to the effectiveness of its other services.

## *What Auspices?*

Beyond this I think that the auspices under which homemaker service should be given is an issue which is best laid aside for some time. Too little experimentation has taken place for a conclusive judgment to be formed or to lay the basis for standards in this respect. Whether such a service should be given through a single-function agency serving all agencies in the community, whether it is more natural for it to be offered through a family-casework or public welfare agency, or whether it should exist in all agencies providing some kind of service to families are questions which should await further experimentation and experience. The main point to be kept in sight in seeking the answers is that homemakers must be made available in an effective way by all agencies that are attempting to cope with the care of children, in their own homes or out of their own homes, and that it must be provided under such auspices and organized in such a way as to assure this degree of availability and effectiveness.

The job of interpreting and publicizing homemaker service to the general public should not be too difficult since, after all, this way of doing things is indigenous to the American culture. There are few people who at some time during their own childhood or parenthood have not made use of a "homemaker"—an Aunt Minnie, related by blood or friendship, who was called in to take over while Mother was away in the hospital or because of some other emergency could not carry on her normal functions. It has been a common experience in American families—but one that our increasing mobility and changing family patterns is making more difficult for families to arrange on their own. Something that has been experienced can be understood and visualized.

While I feel some dissatisfaction with the term "homemaker service," as lacking in dramatic quality, I believe the service itself holds dramatic appeal for all income groups. It could be as necessary for the family with an income of $25,000 as for the family of $3,000. Examples of its usefulness would make good material for TV and radio dramas and for newspaper and magazine feature stories. The same kind of concentration on homemaker service that has been focused on adoption in recent years might make the public as concerned about the scope and quality of this type of service as it is with adoption services.

As with adoption, the creation of public understanding of what is involved depends on continuing work on standards of service among the agencies already engaged in offering this service or actively concerned with getting it for their clients. In order to make a service understood it is necessary to have a simple explanation of what it is and agreement on how it should be given, what is required for giving it, and what its assets and limitations are. In none of these areas is there complete clarity today.

Little has been written about the difficulties of providing homemaker services. These are many, and until they are faced frankly through discussion and experimentation, the needed clarity will be slow to emerge. Homemaker service must be sold to the public, but, as with any product, if the sales efforts are to be successful continuous attention must be given to improving the product.

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# THE FAMILY APPROACH TO FEEDING CHRONICALLY ILL CHILDREN

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IT HAS OFTEN been observed that tasks are more interesting, and even easier, when several are done at one time. Perhaps this is one reason why the family approach to feeding chronically ill children is so gratifying, involving as it does at least three simultaneous challenges: the feeding needs of childhood; the demands of family feeding; and the special feeding requirements imposed by the chronic disorder. The way these simultaneous challenges are met may spare the child needless damage from the disease, and equally important, may salvage the benefits that sound feeding practices can bring to him and to his whole family.

There are innumerable chronic diseases which beset childhood. They are of infinite variety and may involve any or all systems of the body. Some involve the digestive tract or food utilization. Some, such as those accompanied by fevers or requiring surgery, create increased food needs. Some other conditions have little to do with food per se, but can so preoccupy a family that proper feeding gets overlooked, as may immunizations and other forms of general child care. One pediatrician, for example, was struck with this when called to attend a group of blind preschool children. He said that after the initial shock of being confronted by so many small blind children, the next impact was the realization that the majority of them presented severe nutritional problems. He felt that the parents had been so overwhelmed with the visual problems that they had neglected the usual concerns about childhood feeding.

## *Common Denominators*

Although chronic conditions are numerous and varied, there are common denominators which enable us to get our professional bearings and help children and their families. These are the growth and development tasks of childhood; for, sick or well, children struggle along in an attempt to accomplish these indispensable tasks. They enter into a family approach to the feeding of a child with chronic illness by raising several questions:

1. At this particular child's age, what are the usual nutritional demands of growth and development? What does food and the feeding process need to offer him for his physical growth? for his physical, social, and emotional development?

2. Does the chronic condition from which the child suffers increase, or otherwise alter normal needs: Does it pose obstacles in meeting them? nausea? pain? fatigue? loss of appetite from drugs? or does it raise other impediments?

3. How can the growth and development needs be reconciled with the demands of the illness?

4. How can the resultant dietary plan for the child be brought into harmony with sound feeding practices for the whole family, so that insofar as possible it can strengthen and unite the entire family rather

Mealtime in most families, as in this one, is the time of sociability in which it is important for a child who is chronically ill to share. Dietary restrictions should be handled in a way that will set him apart from others as little as possible.

than weaken family feeding and family unity as it does when the focus is on one member of the group and includes only dietary treatment?

These basic considerations are worth considering even in a short-term illness. They become imperative in long-term disability. The differences in planning for a short illness and planning for a long period of disability are like the differences in planning for a short storm and planning for a poor climate. Long-term stresses of climate or of chronic disorders cannot be met with makeshift temporary approaches that might suffice for a short emergency. Situations of lasting stress require the best provisions our minds can contrive. In respect to feeding, this means that in chronic disability, the closer the feeding practices can come to meeting the needs of childhood, and of families, the sounder those practices are likely to be.

In feeding children, we usually get our bearings by thinking of "ages and stages." For example, from the physical standpoint we recognize clear distinctions between the infant, the preschool child, the elementary-school child, and the adolescent.

In infancy we see a characteristically rapid growth, very early advanced motor controls of lips, mouth, and throat, and gradual establishment of motor mastery in other parts of the body. Then in the preschool period we see almost constant motor activity, and slower, but still-continuing growth.

In the little school child we see continued strenuous physical activity, and an increase in stockiness of build, though a lessened linear growth. The child now faces the onslaughts of the common communicable diseases and the physical demands of preparing for the growth spurts of adolescence.

In regard to adolescents we must be aware of additional growth needs and of possible problems of obesity and acne. In addition, persons who fully contemplate nutritional needs will always bear in mind the thought that the nutritional needs of adolescent girls must be regarded as "pre-prenatal."

While all these developments are going on physically, mental development is being influenced too, especially in infancy and early childhood, for feeding is a learning experience. The mouth is a sensory organ of prime importance. A physician acquaints himself with his patient through the classical approaches of inspection, palpation, auscultation, and percussion. The child acquaints himself with his environment in the same way, but he uses his mouth to inspect, to palpate (that is, to *feel*), auscultate (listen), and to percuss (rap and bite), and to get the general knowledge of the world about him.

Feeding needs to be conducted in a way that lets these tasks be accomplished. The child needs opportunity to chew goodness from meat, even if that means that for a few weeks he does not want to swallow what remains after he has extracted the flavor. He needs opportunity to learn to make new uses of his newly acquired eye-hand-mouth techniques, using them now not only to locate things and to put them in his mouth, but also to retrieve strange-feeling or strange-tasting items with his fingers, and to eye them studiously. He also needs a chance to learn to cope with slippery foods, and to become acquainted with the pleasures and annoyances of variations in sweetness, sourness, and intensity of flavors.

Emotional considerations are of paramount importance in family feeding. Children grow physically according to general patterns, passing through the same stages in the same order, but not necessarily at the same rate. Social and emotional growth behave similarly, having general patterns but high degrees of individualization. These emotional "ages and stages" are closely related to feeding needs.

## *Feeding Needs*

***The infant's task*** is to work toward security and to acquire a sense of trust. Through satisfaction of hunger demands, he gets a feeling of the world as a dependable place,[1] and in the course of the feeding process he and the feeder delight each other and launch what is for him the first of a lifetime of interpersonal relationships.

Infant feeding works best when it is close to another human being. Bottle propping is to be deplored, not only because of the hazards of aspiration pneumonia, but because the baby needs to feast not only on the bottle's contents but also on human companionship—especially the mother's. Erich Fromm speaks of the difference between a woman who can give her children milk and one who can give them "milk and honey." The "honey" part requires the closeness of human companionship, which is the beginning of the child's closeness with the family.[2]

***The preschool child*** strives for mastery of his body and himself and for some degree of independence. He works almost incessantly during his waking hours—climbing, running, pulling, tugging, shoving, and investigating. Just as these large muscle pursuits of autonomy require calories and good foodstuffs, they also require imagination, independence, and initiative in feeding. Since children are highly imitative, adult and peer examples are important. Children are quick to follow good (or bad) examples at the family table. This is true not just of etiquette, but of eating patterns.

Readiness and ritual need to be considered, too. Young children have a readiness to experiment which they may not have later, yet at the same time they show a love of ritual which parents can utilize to reenforce good feeding practices and to strengthen family ties. The children can be fed at least part of the time with the family. At this age feeding practices for normal children can be brought so close to family feeding that the child's nutritional needs can be regarded as the core of a family-meal plan, which with slight variations can be made interesting and palatable for the entire family. Child feeding can thus serve as the beginning of lasting improvements in total family diet. Well-planned meals for a child at this crucial period can establish good dietary patterns for the family, and for the child for his whole lifetime.

***The adolescent*** usually tries to loosen old ties with childhood and home, and in so doing clings tightly to his own age group and turns to young adult figures that he can admire and copy. Young people in this age group need to be able to conform as much as possible and to be, within reasonable limits, in charge of their own dietary regimes. They are almost constitutionally obliged to break rules laid down by parents and other authority figures so that this becomes an extraordinarily dangerous period for such groups as the rigidly dieted diabetic.[3]

### *Family Approaches*

In dealing with chronic illness, we must think of the special dietary requirements for the particular chronically ill child at his particular age, and then consider to what extent those requirements can be derived from family care that would be suitable for the whole family. Additions, deletions, and modifications may then have to be made for the child—or perhaps for the rest of the family—but the part of the food which they can all share needs to be clearly established, for that becomes the foundation on which salutary influences can be built.

During his school years a child has a great need for a sense of accomplishment. He is at an age when it is normal to try to keep up with other children, and a sense of failure in this may be reflected in eating problems—overeating for consolation, or loss of appetite out of sheer discouragement. In addition, of course, physical inadequacies stemming from poor nutrition may actually be factors predisposing to real personal failures.

Anything we do to increase a valid sense of personal worth in a child may help him to move on to further maturity. This has important implications for our dealings with a child whose activities or diet must be curtailed because of chronic disease. It makes a great difference to a child whether treatment makes him feel cherished or chastised.

One family may deal with dietary prescriptions in such a way that their child recognizes the dietary modifications as a form of cherishing and care on his behalf, enforced because his family love him deeply. Another family may administer the very same prescription in such a manner that their child feels punished and deprived.

These contrasts are often seen in orthopedic clinics where efforts are made to hold weight down. Some families and some health personnel present diet restrictions in a way that make children feel ashamed and unhappy. They may even alienate children from the clinic. Such unfortunate approaches can be a frequent cause of clinic absenteeism. Appointments may be broken because of embarrassment at weight gain and dread of scoldings, humiliations, or derision.

Punitive pressures in diet restriction are resented, but so are loose generalizations. Some orthopedic clinics have found it important in obesity not to just tell children to "be careful" with their diet but to get right down to work with them and their families in a specific approach to the whole subject of the child's and family's diet.[4]

Chronic illness prescriptions for adolescents need to be as unembarrassing as possible. When adult guidance and supervision in regard to them are necessary they might better come from someone outside the home, someone the adolescent does not need to defy, but may even wish to emulate. An adolescent may be able to derive "peer help" from others of his own age group who happen to be on similar restrictions.

## *Feeding and Sociability*

Feeding and sociability go together, but dangers ensue when food is used as a substitute for comforting companionship. If there are deficits in the social aspects of living, food may be used to make up the difference. For example, in infancy there is noticeable dawdling over feeding by children who are put down too promptly at the end of the feeding instead of having a little postprandial cuddling and sociability. In contrast, the preschool child's sociability needs may be such that he climbs down from the table and runs away to join his friends without finishing his meal.

School children and adolescents may eat for comfort and companionship if sociability needs are not met elsewhere. Some families tend to use the house chiefly as a dressing, sleeping, and feeding center, rather than as a center for being together. In such establishments children of a certain temperament may prolong and extend their feeding time—and food intake—in an effort to eke out and prolong the available companionship.

If feeding sociability has to be curtailed for a chronically ill child it is necessary to consider, along with other dietary planning, how some other tightly knit form of family sociability might be encouraged which would include him. For example, the family might gather around the sick child for such activities as playing games, designing Christmas cards, planning a vacation trip, or another shared occupation and thus achieve the "togetherness" normally found at the dinner table.

Family feeding even in health seems to work best when related closely to the cultural patterns of the family and their congenial associates. For example, in certain groups cottage cheese and sour cream are greatly enjoyed items, whereas in other groups they are almost offensive. The closer the chronic-disease diet—or any childhood diet for that matter—can fit into the enjoyed cultural practices of the family, the more likely that diet is to become a lasting pattern of eating and not just a therapeutic gymnastic carried on during a health crisis.

Closeness to cultural patterns seems to help, too, in making it possible for the child to snuggle up against the supports of family ritual, an experience pleasing to most children, and particularly salutary to those whose illness and its prescriptions tend to keep them from being completely integrated into the family group.

Chronic illlness strains the family purse, which is seldom very full anyway in families with young children. Food is usually one of the first items on which a family tries to curtail expenses, as other big expenses—rent or housing costs, and medical care—are often difficult or impossible to alter.[4] Many families show more courage than competence in these efforts. There are few ways in which families can accomplish more good in the feeding of a child with chronic illness than through the help of a nutritionist collaborating with a social worker or budget counselor.

## *In Summary*

In childhood there are innumerable varieties of chronic conditions requiring dietary care. Sometimes all that is needed is a simple increase in the wholesome fare suitable for any child. Other conditions demand all manner of dietary modifications, restrictions, or special inclusions. But whatever the chronic disease and whatever its special prescription, there are also other considerations to be met. These include the needs of normal growth and development involving the child in relation to his whole family.

Widening the angle of dietary vision to include the whole family is the basic and most logical way to feed a child. This not only helps the chronically ill child but may benefit the entire family.

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# THE SOURCES OF PARENT BEHAVIOR

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PARENT EDUCATION can be justified only on the grounds that it will leave some effect on the behavior and belief of an individual striving to fulfill his role as a parent. This leads us to the crucial question: Can we assume that parent behavior arises from sources that can be influenced by educational methods?

Education generally, and parent education specifically, assumes a form of human behavior in which some share of the individual's action is subject to conscious, voluntary control. According to this assumption he is able to set goals for himself, to evaluate and then select means of reaching these goals, and to put them into practice. Education therefore appeals to the conscious and rational elements of the individual, supplying him with information, suggesting new values he can pursue, and providing him with elements of conscious and rational problem-solving skills that better equip him to make decisons.

Parent behavior, of course, is not fully accounted for by this assumption. Many segments of behavior are not the simple expression of goal seeking in which the individual consciously selects the best means at his disposal and uses them. Other factors that may limit the effectiveness of educational programs must be faced in parent-education planning.

In addition to the rational, self-controlled factors implicit in educational programs, at least five types of causes of parent behavior can be identified, as follows: unconscious factors; cultural values; interpersonal and social controls; group structural determinants; and ecological or physical factors. In connection with all these, the individual behaves in his parent role as part of a social system. He engages in behavior vis-a-vis the child in interactions that are regulated by social norm. He also is restricted by his own repressed and unconscious motives, which work to determine his behavior in his parent-role performance in ways unknown to him. Moreover, the pressures of time and the demands of the conflicting social situations in which a large family is involved, as well as restrictions caused by absence of certain economic goods—whether living space, toys, or more generally of money, all work to limit the applicability to the parent of the assumption of conscious and self-controlled performance.

The critical issue is the degree to which these restricting factors reduce the influence of education upon the parents' role performance. Thus to supply factual information or discuss the range of values to be selected by the parent may not mean that he will use the help if he has unconscious motives that cause him to distort or, indeed, not even to remember what he has learned. Nor is it useful to do this if the mother who is given information leading her to a new course of child rearing is unable to put it into practice because a dominating husband forbids her to do so. Also, it would seem of little value, and indeed cruel, to discuss the merits of establishing a nurturant and intimate relation with children if the mother of a large number of

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**Based on a paper presented at the 1958 Institute for Workers in Parent Education, sponsored by the Child Study Association of America.**

children has to work away from home in order to provide for them.

In general parent educators have been most sensitive to the limitation on the educability of parents arising from unconscious motives. The issue of education versus therapy as a method of influence has long been argued among them.

To some extent parent educators have been sensitive also to the limitations imposed by economic and environmental factors, although these have not been stressed sufficiently. Almost no attention has been paid to the problems of power relations or of social control in the family, or to the limitations placed on performance by internalized cultural values. Group structural determinants also have been overlooked. Let us now consider these categories in order:

### *Unconscious Factors*

Consider a parent who has been forced as a child to learn to repress his aggressive feelings and is frightened and shocked when aggression occurs between children in his family. His alarm arises from his own anxiety lest he express his own aggression, but he does not know this is the reason. With this parent, it seems useless to discuss sibling relations and advocate the permission of a moderate display of aggression between siblings, since the parent does not understand the origin of his own feelings about aggression and is unable to change them simply through exposure to education. To influence such a parent requires therapeutic procedures in order to help him understand the source of his feelings, thus making them amenable to educational influence.

No doubt every parent shows the influence of unconscious factors. The rich clinical case histories in parent behavior [1] continually illustrate this. The fact that these cases are based on clinical subjects mitigates against their general applicability to normal parents, but much research based on samples of normal parents supports this point. For example, a recent work by Sears et al.[2] reports a significant positive relation between sex anxiety in mothers and a refusal to breast feed, thus suggesting that the refusal is an expression of a general anxiety over matters pertaining to sex. The authors point out that education directed to the performance of breast feeding is likely to be discomforting for the mother who resists the practice because of unconscious factors producing sex anxiety.

Many parent-education programs have not seriously considered the limitations unconscious factors place on such education or the modifications required of their conception of the parent as a consciously self-determining actor. Given the fact that for almost all parents some aspects of their role, and for some parents almost all such aspects, are influenced by unconscious factors, it follows that there will be parental feelings and and behavior not influenceable by the parent educators' efforts.

Ideally parent educators would tailor their programs to persons and child-rearing areas open to education. Had they prior information on who such people are and what the areas are, this would be easy. Lacking such information, the educator must recognize with a given parent the areas of child rearing in which the parent's unconscious resists educational influence, and he must limit his program accordingly. To do this the parent educator needs special training.

Though some parent educators have underestimated the role of the unconscious, others have been so heavily influenced by clinical theory stressing the unconscious that they do not fulfill their possibilities as educators and even ask whether educational efforts are justified at all.

There has been an increasing tendency to consider the attitudinal and emotional characteristic of the parent, in contrast to the behavioral, as having the most influence upon the child. Clinicians stress that it is especially these emotional characteristics that are under unconscious control. This has led directly to questioning the justification of parent education. At least one parent educator [3] has adopted the position that the proper role of the parent educator is to be supportive and comforting to the parent and that attempts to change parents through education result in the production of anxiety and in poorer child rearing.

In contrast, some major studies [4] [5] show that deep-seated personality changes occur in the course of time in individuals, entirely apart from the effects of therapy. Kelly summarizes as follows: "Our findings indicate that significant changes in the human personality may continue to occur during the years of adulthood. Such changes, while neither so large nor sudden as to threaten the continuity of the self-percept or impair one's day-to-day interpersonal relations, are potentially of sufficient magnitude to offer a basis of fact for those who dare to hope for continual psychological growth during the adult years."

The evidence argues for the presence both of conscious and unconscious determinants of parent-role performance; but in spite of the long-time interest in this problem and the heat that has been generated in regard to it, no one can say what percentage of parent behavior, in what areas of child rearing, or among what kinds of parents, is determined by unconscious factors. One can ask the question: Is it 10 percent, 50 percent, or 90 percent, but cannot cite any research data.

We need to find out how unconscious determinants of the parent role are distributed among individuals and to avoid either a blanket rejection of educational efforts on the grounds that unconscious feelings are all-important or the reverse position of ridiculing the role of the unconscious. Appropriate research on this aspect of the causes of parent behavior is badly needed.

### *Cultural Values*

A second assumption is that much parent behavior springs from internalized cultural norms. This is to say that parents perform their role on an habitual basis, pursuing ends that they have learned from the general society in which they live, but of which they are not fully aware. Efforts to change parent-role performance may run up against these determinants. These are difficult for the parent to recognize and moreover are usually deeply rooted and closely intertwined with the larger culture and its values, which must change before the parent role can change.

This raises the question of whether much that is alleged to be unconscious only appears to be so and constitutes rather internalized aspects of the culture, the latter being not actively repressed but simply preconscious. Though a parent may not think about such culture norms and values, they may be brought out under stimulation of educational procedures and, once in the open, can be altered by education.

For example, a study [6] of the child-feeding practices of mothers from different subcultures shows a clear demarcation between mothers who are concerned about their child's eating because they wish the child to be healthy and those who are concerned because they want him to be large. When such mothers are exposed to an educational program emphasizing permissive feeding, those concerned about their child's health adopt permissive practices since an educator is able to demonstrate to them that the child's self selected diet can produce good nutrition. The educational program is comparatively unsuccessful, however, with the mothers who wish their children to be large, since self selection of diet does not normally produce an especially large child.

To teach some mothers the value of permissive feeding, the parent educator has to make clear to them the basis of their concern over the child's eating and deal directly with their cultural values.

One of the results of parent education has been a tendency of parents to become dependent on professional workers in child care and other family matters. The parent challenged as to his basic beliefs about child rearing turns to the parent educator to provide him with a new set of means and ends for raising his children and relies upon these. If a parent educator seeks his own ends rather than those of the parent, he now has a willing and compliant follower. But if he aims to make the parent more competent to seek his own values, he must now help the parent stand on his own feet and must work with him until he has consciously and independently selected his own new set of values.

Parent education in this country probably has not needed to be especially concerned about the effect of internalized cultural values on parent-role performance. This is because our subcultural groups, with different values, are in contact with one another—a contact increased by our marked social-class and spatial mobility. Through this contact the respective values of the groups are challenged and each group is led to compare its values with those of others.

### *Interpersonal and Social Controls*

Parent education can be viewed as an attempt to influence and change the role of the parents. This role, like all others in social-interaction systems, is a set of regulated ways of behaving and of prescribed ends that are consonant with the social system of which it is a part. The individual seeks to discharge his parental responsibilities in a way that elicits approval from the groups to which he belongs or at least avoids their censure. He knows the behavior prescribed for him and he knows the censure resulting from failure to conform.

Nevertheless, much parent education seems to operate almost as if the parent existed in a social vacuum, instead of being imbedded in a social situation involving the other parent, relatives, and the community, all concerned about how he behaves. Other members of society have the legitimate authority to exercise control over parents' role performance so as to make certain that the values prescribed for the role are sought and the appropriate means used. The omnipresent other spouse, the close relative such as the parent's parent, not to speak of other relatives and neighbors, have a right to try to influence the parent also.

A closely related problem involves the issue of who in the family has the responsibility for making decisions about child-care practices in specific areas. This is seen clearly with respect to the allocation of the decision-making power between a mother and father in a family where responsibility for certain kinds of decisions is customarily given to one spouse. It thus follows that a parent-education program may seek to influence one parent, usually the mother, with regard to aims or means to be sought or used in some child-care area, whereas in fact it is the socially given responsibility of the other parent to determine the practice in this area. Any attempt by one parent, whether under the influence of a parent-education program or not, to usurp the decision-making power that custom gives to the other is apt to be viewed by the other as an intrusion and so resisted.

The father may be the more appropriate person to make decisions involving discipline or the handling of money; in other areas it may be the mother. Moreover, since allocation of decision authority within a family almost certainly varies with social class and cultural background, specification of the program's clientele seems desirable.

The failure of almost all parent-education programs to assess the social setting into which they introduce their educational materials, the failure to recognize that mothers have husbands, mothers, and neighbors, is lamentable since the result of such failure may be friction, resentment, and hostility between husband and wife, usually to the detriment of the child. The model of parent behavior underlying the educational program must recognize that although the parent may seek new values he must obtain approval of other persons before he can adopt them.

### *Group Structural Determinants*

In recent years there has been a rapid growth of sociological research on small groups,[7] dealing with the effects upon behavior of group size, of heterogeneity, of type of leadership, of patterns of communication, and of other characteristics. The family is a small social group, and many of the results of research on small groups other than the family may be found to apply also to the family and in this sense to be pertinent to the question of causes of parent behavior.

Though we now know little about the way in which such structural characteristics as group size may determine parent behavior, this property is discussed here to show why it seems pertinent to parent-education planning and why further research on such structural determinants of family interaction seems of fundamental importance. Since group size influences interaction between group members, parent-role performance may be in part determined by family size.

Research has demonstrated two correlates of group size that seem to have implications for parent behavior. First, several years ago Mills reported a study[8] of three-person ad hoc problem-solving groups, showing that the groups split up into units of two and one, with the isolated member being spoken to less and contributing less to the conversation, and the two members in the coalition interacting much more heavily. Research in progress on groups of other sizes shows that in four-person groups a unit pattern of two and two usually develops, and no member is isolated.

These same patterns may not emerge, it is true, in only-child and two-child families. Indeed, in research[9] on three-person families composed of mother, father, and a son about 12 years old, the development of two-and-one coalitions occurred but was unstable; that is, positions in and out of the coalition tended to rotate among the family members. This argues that cultural norms governing interaction in the family proscribe the continuing isolation of any member of the family, and that parents and child, actively though not necessarily consciously, try to avoid any permanent teaming up of one set of members against another.

Recommendations to parents on how to rear their children, from parent educators or others, may suggest or demand that the parent treat his child in a way that conflicts with the pressures of the group structure. The parent's success may be limited, struggling as he is against powerful determinants deriving from group structure. It is questionable whether it is even good policy to try to set people in opposition to the force of group structure.

As a second example, we refer to research[10] on the rates of participation in discussion by members of college classes of sizes varying up to 12. Analysis of the data plots the relation between the order of group members in participation (who participates most, next most, and so on) and the actual frequency of participation in terms of total number of actions. The relation between these two variables shows up as a curve, with the highest participating member talking twice as much as the next ranking member, who in turn talks a third more than the next rank, and so on. As group size increases, the tail of the curve extends further so that in groups of 6, 7, and up those members low in order of participation talk very little indeed. The ranks are stable across group meetings, as is the relationship to each other.

One would suppose that the rank positions of participation are the expression of personality characteristics of the group members—extroversion, need for affiliation, and the like. However, in a critical test [11] of this hypothesis the earlier results with ad-hoc groups were duplicated and the groups were reconstituted so that new groups were composed of the highest-participating members from the previous groups on the one hand, and the lowest-participating members on the other. In reconstituted groups the distribution of participation showed the same exponential pattern as it did in the first group. This argues effectively for the determining influence of group structure on individual participation rather than of personalities.

### *Intrafamily Participation*

The same pattern of participation probably occurs in the family, around the dinner table or during an evening in the living room. Thus different members of the family would fall into different ranks of participation. Hence both parent and child are exposed by virtue of this group-structure determinant to continuing and systematic differences in their interaction in the family. As family size increases, the members who participate least assume a position in which their participation becomes very little.

The normative regulation of family interaction has its counterpart in participation also. Probably parents seek to equalize the participation of children in family matters and thus prevent development of a pattern in which one child participates greatly and another becomes withdrawn. The difficulty of preventing this must increase as family size increases, and it may be that in four- or five-child families it is impossible.

Other findings of probable pertinence include those showing that members in groups of an even-numbered size are more antagonistic than those in an odd-numbered size, and that both tolerance of deviation and lower levels of tension in interaction accompany increasing group size.

In sum, parent-education programs may be asking parents to behave in ways that are extremely difficult, perhaps impossible, because they are at cross purposes with the determinants of parent behavior inherent in the group structure.

### *Ecological and Physical Factors*

Parent educators vary considerably in their understanding of ecological aspects of the parent's role. On the one hand the written materials of the Children's Bureau, U. S. Department of Health, Education, and Welfare, avoid making recommendations with which physical or ecological factors would interfere. On the other hand some works show little sensitivity to the trials of the average parent, as in the Gesell and Ilg descriptions of the typical behavior days of children at given ages.[12]

As there is apparently no research relating the parent's physical environment to his child-rearing practices, we can only speculate on ways in which ecological factors are important. A few examples of the way in which such factors may influence the parent point to the need for greater understanding of this relation.

Consider the effects of poverty upon a home where the absence of labor-saving devices, of assistance in child care in the form of babysitters or other persons, and of adequate medical care, plus the depressing nature of the surroundings, may make it hard indeed to be cheerful, to be resourceful and creative in child rearing, and to give deliberate attention to the parental role.

Consider also the fact that in this country nearly 7 million women with children under 18 are in the labor force. The mother's working has consequence of several kinds for her family role. In such a family the older children are frequently pressed into service to act as parent substitutes. The working mother who sees her children for only a short time during the day must compress into this period all the nurturance and discipline that other mothers distribute throughout the day.

Note the various effects of physical crowding caused by restricted housing space—the increased frequency of physical exposure between brother and sister, between parents and children; of overstimulation between family members, which may lead to attrition in the emotional equanimity of the mother. In such conditions a mother may find it very difficult to maintain the level of acceptance and supportiveness for her children held by a mother who can withdraw and so regenerate her emotional resources.

Such examples suggest the need for further research to differentiate parents and methods of parent education in relation to the child-care practices that family environment permits.

### *Conclusion*

The applicability of the basic parent-education assumption that the parent is autonomous and deliberately and consciously selects his ends and means in child rearing probably varies. It may apply more to training youngsters to use money than in training them to control sexual motivation or aggression. Moreover, the applicability probably also varies with the individual, since parents differ in the degree to which their behavior has these conscious volitional and rational aspects. Certainly much research is needed in this respect to clarify further the validity of parent-education assumptions.

Recognition of the many contributing causes of parent behavior leads to closer examination of the limitations of parent education. This is valuable in helping to avoid educational efforts that not only hold no promise of success, but which if pushed in opposition to the influences of other determinants of parent behavior can result only in frustration on the part of educator and parent alike.

Recognition of the various causes of parent behavior leads also to an appreciation of the value of the programs that stem from these rather different conceptions of man. Thus, one can recognize that where some aspect of parent behavior arises from unconscious and repressed motives the means of change involve therapeutic procedures. One understands that when change is asked of a mother in an area where the husband has authority that the change also will involve efforts to change his beliefs. Where factors in the physical environment impede changes in child-rearing practices the program emphasis may have to be on environmental manipulation.

Thus it is useless to raise the question of which kind of program—educational, therapeutic, eugenic, or environmental manipulation—is the "right" program. All programs may proceed from valid assumptions. The adequacy of such assumptions, however, and hence the program, varies according to the individual client, the area of role performance involved, and other characteristics. Therefore it is impossible to discuss questions of which therapy or education or other programs are better than others without reference to the programs' application in a specific situation. It would seem, too, that certain kinds of parent behavior that may produce troubles for the child cannot be dealt with successfully by single measures, but require instead a full-scale attack. For example, certain aspects of parent behavior involved in the production of mental illness in a child may stem from many causes and hence may require not only therapeutic procedures for the parent, education, or raising the family's economic level, but all of these and others besides for the achievement of change.

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**It is the misuse of human power which we have most to fear.**
*Frank Fremont-Smith, M. D., to the American Orthopsychiatric Association, 1958.*

# PARENTS' GROUPS IN PROTECTIVE SERVICES

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PUBLIC AGENCIES can improve their services to neglectful parents through the use of parent meetings. This has been demonstrated by the success that the Protective Service Division of the Jefferson County Welfare Department, Louisville, Ky., has had in conducting discussion meetings for parents who have come to the division's attention on complaints that they have neglected or abused their children. The meetings supplement and reinforce the caseworkers' efforts to help these parents, many of whom tell of having difficulties with their children, but are largely unaware of their own responsibility in this regard.

Most of these parents grew up in homes that badly prepared them for parenthood. Furthermore, they have not attained any preparation through formal or informal education. They are usually overburdened by childbearing and day-to-day living and lack knowledge of many of the elementary principles of child care.

We recognized that our primary purpose as a protective-service agency is the resolution of the problems behind specific complaints regarding the neglect or abuse of children, and that this would have to be done individually. But we came to the conclusion a few years ago that additional help in the principles of child care might be given to our clients in groups if they would be willing to attend meetings. In such groups the parents would have opportunities to meet others with similar problems, to exchange ideas, and to have a social experience. The practical hurdles of babysitter and transportation expenses were overcome when a local church provided funds for these and for refreshments.

### *Getting Under Way*

One of our caseworkers, who had had previous experience in leading group discussions and who understood the problems of families receiving protective service, volunteered to lead the discussions. Arrangements were made for the meetings to be held at a centrally located community settlement house. A rather small room, where everyone could sit around the table, provided an informal atmosphere. We planned evening meetings so that the fathers could attend.

The caseworkers explained the purposes of the meetings to the parents. They emphasized that each person had something to contribute to the others because of his own experience as a parent, and that each could gain from the others. No coercion was used, but the caseworkers did revisit some families in order to encourage them to attend. As far as we know, only two families came reluctantly, feeling that attendance was expected of them, but after the first meeting they too attended willingly. Most of the parents who were invited had already overcome any initial resistance toward the agency that they might have had, and they expressed interest in this method of learning more about ways to become better parents.

The parents with whom we come in contact vary in their ability and capacity to change, and in their desire to do so, as well as in the degree of their cooperation with the agency. We have found that most of them do not intentionally neglect their children and really want to be good parents. By assuming this during our initial contacts with them

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**Based on a paper presented at the 1958 forum of the National Conference on Social Welfare.**

we are usually able to overcome any resistance or hostility, so that the parents become willing to work with us. On the whole, the clients who have attended the meetings have seemed to develop a closer feeling for the agency as time goes on.

The original invitation list consisted of 13 families; this list increased to 24, and it varied throughout the series as new names were added and others were eliminated because of withdrawals. Nine members attended almost all the meetings, which took place every 2 weeks over a 6-month period. A core group of 14 persons consisted of 4 couples; 3 married women whose husbands were not in the home; 1 unmarried mother; and 2 married women whose husbands did not attend. The ages ranged from 21 to 50 years. All the families but one were of extremely low economic status. The intellectual level varied. Both whites and Negroes attended.

### *The Content*

As a starting point the group leader prepared an outline of topics to be covered during the series, but she allowed the meetings to be directed to the needs expressed by the group. The members spoke up freely about what they wanted discussed, and the discussions generally extended to topics that the agency considered important for them—such as discipline, normal child growth and development, and parent-child relationships. The group expressed such interest in husband-wife relationships that this subject was discussed at some length, and the members finally related their problems in this area to the problems they had with their children.

The leader used methods such as role playing and program aids such as pamphlets and an occasional film. An additional tool now being considered is the use of resource persons.

Recording was considered essential for group evaluation and for the information of the caseworkers. We have experimented with various methods of recording and, with the approval of the group, now have an additional staff member sitting in as recorder.

At the first meeting, the parents were somewhat aloof but they soon seemed to feel at ease and began to talk freely about themselves and their problems. As the meetings progressed they showed signs of more and more security.

The increasing ability of the group to assume responsibility for the direction of the discussion was demonstrated by the manner in which the meetings changed. The first meeting was opened by the leader, by introducing the members and reviewing the objectives of the series. At the beginning of each of the next two meetings she asked what the group planned to discuss. However, when the group assembled for the fourth meeting one of the members immediately presented a problem she wanted discussed. From then on, the members themselves suggested the topics for discussion.

The effect of the growing security of the members in interacting with the group was illustrated by the changes in Mr. and Mrs. White. When Mr. White joined the group, he apologized for his stuttering. The other members gave him considerable reassurance and acceptance. They talked about how verbal problems could be influenced by emotional problems. This ultimately led to a discussion of stage fright and of speaking in a group. The ability to function better when one felt sure of oneself was discussed at some length. As the meetings progressed, Mr. White's speech difficulty became less and less noticeable. His improvement was noted by the group three meetings later, and the reasons for the improvement were discussed. Mr. White's explanation was, "I can talk better now because you understand me and my problems." Other members said that they too now felt comfortable with the group because they felt accepted and knew what to expect. The leader then helped the members relate these ideas to children and their need to feel safe and comfortable.

Mrs. White seemed embarrassed by many of her husband's remarks during the first meeting, and tears would come to her eyes. By the second meeting she seemed completely at ease, laughed a lot, and entered into the discussion more readily. She also supported her husband's opinions and ideas. The group's acceptance of her husband, as well as of herself, was undoubtedly responsible for this change.

The group quickly identified with the purpose of the meetings, and by the second meeting was actively and enthusiastically engaged in problem solving. The "we" feeling or group spirit was evident during the third meeting and continued throughout the series. All the members took special interest in helping fellow members understand and find solutions to their problems. Each expressed a need to introduce personal problems, but the members were surprisingly willing to subordinate their needs to the needs of their members.

For example, at the end of the third meeting, which had been primarily devoted to teen-age problems, Mr. White, the father of teen-agers, pointed out that while the parents of younger children might profit in the future from discussion of teen-age problems, the next session should be concerned with younger children so that other parents could bring up their current problems. Another member offered to visit a couple who had been absent. On another occasion a member offered to help an unemployed father find a job.

The members of the group soon recognized the helpfulness of knowing that other people have problems and feelings similar to their own. To one member, who had feelings of inadequacy because of his financial situation, this recognition seemed to come as a shock. He said he was amazed to learn that the majority of those present had serious financial problems and that some were worse off than he. The mutuality of the members' problems seemed to produce a bond between them.

## *Group Feeling*

The members expressed appreciation of the meetings and a desire for other parents to have the same satisfying experience. One member wanted his neighbors to know he was part of such a group.

Considerable interest in meetings of this type had been expressed by a number of agencies and individuals in the community, and our agency wanted to share the results of this experience with them. The members of the group seemed pleased with the idea of publicity that might help to interest others in joining future groups sponsored by the agency or in forming their own groups.

When the possibility of inviting a reporter to sit in on one of the meetings was suggested, the members responded enthusiastically, saying that this would be the best way to explain the meetings. We, of course, would not have gone ahead without their approval. They showed their pride in being identified with the group by indicating a willingness to have their names used even when assured that this was not necessary. They said they wanted others to know that they were trying to improve themselves as parents.

In order to protect the members, we talked the whole matter over ahead of time with a reporter whom we selected because of his knowledge of social agencies and his sincere respect for people. He agreed to call the members "parents with problems," who had been referred to the Protective Service Division for casework help.

The following example illustrates the warmth, friendliness, and acceptance, as well as the group feeling, that existed in the meetings.

The Martins joined the group for the first time at the fifth session. Mr. Martin had a "chip on the shoulder" attitude. He dominated the meeting, talking in an almost compulsive manner. He was defensive, antagonistic, and suspicious of the acceptance and friendliness of the group. As Mr. Martin dogmatically advocated various methods of discipline for children, the leader attempted to emphasize and utilize any positives in what he was saying. The group attempted to follow suit. For example, as Mr. Martin advocated harsh methods of discipline, Mr. White would attempt to clarify his statements, emphasizing agreement with the need for firm discipline, but distinguishing between firm discipline and harsh measures that reflect rejection. At one time during the evening, Mr. Martin asked the members of the group just what they were trying to do. Their explanation revealed a clear understanding of the purpose of the meetings and showed how they had been helped by them. Typical was the statement: "We talk over our problems and give each other ideas."

When the session ended, several members of the group urged Mr. Martin to return to the next meeting. He said he would probably not come again and expressed doubt about the value of the meetings and his ability to participate in them. Several of the members again explained to him the purpose of the meetings and reassured him about his ability to participate. Their efforts to help Mr. Martin feel accepted and wanted were sincere and friendly.

Later in the week, Mrs. Martin told the caseworker that her husband had had such an enjoyable time that he could hardly wait until the next meeting. The Martins attended every meeting from then on and are currently attending this year's sessions.

## *The Effects*

Many members of the group made sincere attempts to apply at home some of the ideas developed in the meetings. One discussion of husband-wife relationships illustrates these efforts:

Mr. Johnson complained that his wife never had time for him, and several husbands and wives said that they had similar problems. Mrs. Johnson admitted that her husband's complaint was valid, but said that she was unable to do things differently because of her many chores. Mr. West told about some similar problems that he and his wife had been able to work out by talking them over. Mrs. Johnson reviewed her schedule and some of the practical problems involved, giving many reasons why she could not solve her problem. Mr. West said, "It looks like you don't want time with one another." This seemed to set Mrs. Johnson back for a moment and she did not respond.

The group then suggested to the Johnsons and the others who had this problem that the husband and wife sit down and discuss the matter, each considering the other's needs and schedule, and find some time they could spend together. Mrs. Johnson, and also Mrs. Roby, whose husband did not attend the meetings, agreed to try. At this point Mrs. Kerwin, whose husband had deserted, interrupted to comment laughingly, "I certainly wish that I had that problem now; I sure would know how to solve it." Although she said this with humor and everyone was amused, it obviously carried home a point to the wives who were fortunate enough to still interest their husbands.

At the next meeting, the leader showed a film entitled "In Time of Trouble," which depicted some of the marital problems discussed at the previous meeting. A lively discussion of wives finding time for their husbands ensued. Mrs. Roby contributed an account of recent improvement in her home which she had brought about by making a point of leaving the dishes in the sink and sitting down in the living room with her husband for an hour or two of conversation. She said she felt that her husband appreciated what she was doing, and she gave examples of how he had become more considerate of her. The Johnsons said they had tried to set aside some time to spend with each other and had found this beneficial, although they still had problems.

The group leader attempted to help the members see that their children's concept of marriage is based on the example set by their parents. In this connection, Mr. White talked about the way his stepdaughter belittled him to his wife and constantly urged her mother to divorce him because of his inability to earn a living. The group members encouraged Mrs. White to tell them how she thought she might handle this problem. She said that she would tell her daughter that her husband is her choice, that it is her marriage, and that her daughter may make her own choice about whom she will marry and the kind of marriage she will have. Mrs. White spoke with sincerity about her feelings of responsibility and loyalty toward her husband and her desire to be a partner in the marriage regardless of the problems that arose. Mr. White was obviously touched by her remarks and asked, "Why don't you say things like that to me at home?" Without embarrassment Mrs. White replied that she thought he knew how she felt. Later, during an interview with his caseworker, Mr. White spoke enthusiastically about the meetings and particularly about the leader's ability to help his wife speak up as she did at the meeting. He had never heard her do this before.

### *Helping Each Other*

On one occasion Mr. White described an incident that had taken place when he was out working with his 11-year-old son. He started teasing the boy about girls, particularly about one long telephone conversation the boy had had with a girl. Shortly after that the boy disappeared, and when it came time to go home, he could not be found. Mr. White regarded his son's running away as a case of disobedience. The others in the group disagreed. "You shouldn't kid children," said Mrs. Cook. "It makes them feel small and inferior." Mr. Martin commented, "You teased him about something he was sensitive to. He didn't like it, so he ran off." Mr. White then told about trying to make amends by buying a fishing rod for the boy. Another member then asked, "But why didn't you apologize to him?" "Apologize—to a child?" Mr. White retorted. "I wouldn't apologize to a child unless I was seriously wrong." "But giving him the fishing rod was an apology," said Mrs. Cook. "And I think it was misleading," put in another. "Suppose there comes a time when you can't give him something." After a number of other general comments by other members about teasing, Mr. White admitted, "Well, I've learned this lesson—never to tease my boy about girls."

Some of the participants demonstrated a great deal of insight and understanding. At times they were rather direct in their efforts to help others understand their own behavior better.

On a number of occasions Mr. Johnson had his inconsistencies pointed out to him by another member of the group, who encouraged him to reevaluate his methods of dealing with his children. For example, Mrs. Kerwin said, "You make exceptions for yourself and are able to give many excuses, but you do not do the same thing for others. Surely you can make exceptions for your own children." Mr. Johnson, who had joined the meetings with a rigid set of ideas, at first became confused as he began to question his own methods. He became anxious as he expressed a desire to change, but an inability to do so. He asked, "Is there any hope for a person like me?" His acceptance by the group and reassurance by his caseworker in individual interviews helped to relieve his anxiety as he attempted to assimilate new concepts and methods and incorporate them into his life.

The outstanding example of group feeling occurred when the group arranged a surprise shower for Mrs. White, who was expecting a baby. All were enthusiastic about the plan, and at the next meeting the Whites were overwhelmed by the thoughtfulness of their new friends. Mrs. White had had five children, but had never been given a shower before, and most of the other parents had never participated in such an activity.

### *Various Uses*

During the period when the first meetings were being held, the caseworkers were occupied with getting people to join and to return. We had not really expected the resultant enthusiasm. As the meetings progressed and our initial fears of failure proved unfounded, we realized that the meetings could be used in several ways to improve our service to clients.

A new service concept emerged as we found that the meetings could supplement our casework efforts with parents whose children were no longer seriously neglected or abused. The following case illustrates this process:

Mrs. Kerwin, a young woman with eight children, whose husband had deserted the family, had been living with her relatives in a dilapidated coal shed. Nineteen people were living in the one room, with insufficient furniture and heat. The children were usually found completely unclothed and dirty. We had worked on this case for several years, persisting in our efforts to help the young mother obtain suitable housing. Our casework service was focused on cleanliness, proper care and supervision of the children, improvement in physical surroundings, and the mother's conduct with men as well as other relationships as they affected the care of the children. When these problems seemed to have been resolved, we could have terminated our contact, for as the worker reevaluated the situation with Mrs. Kerwin, both recognized that the children were no longer neglected. However, the mother was able to see that she needed better understanding of the emotional needs of her children. We felt an obligation to help her with this and suggested that she might benefit from our group meetings.

Mrs. Kerwin joined the parents' group, attended regularly, and participated enthusiastically. Her increased understanding and her desire to apply her new knowledge was revealed through her answers to theoretical questions, as well as her comments on how she handled specific problems at home. She became increasingly aware of the way in which adults can be affected by childhood experiences, and was able to offer personal illustrations of this. For example, she expressed resentment of the extreme criticism she had received as a child and talked about her efforts to be more understanding about what she expected of her children. She told about allowing the children to wash dishes their own way even if she had to do them over after the children went to bed.

When the first series of meetings was completed we closed this case, knowing we had done much more than effect a temporary adjustment. We had been able to reach this mother while her children were still young and to provide her with the opportunity to develop more fully her potentials for being a good mother. This was a truly preventive service.

Another case shows how group participation and individual casework can interact to provide a more effective service to clients. The Andrews family was referred to us on complaint of abuse of a 16-month-old child. Mrs. Andrews was harassed by the care of six children. Over a period of time we found no recurrence of the abuse, but did spend much time trying to motivate the parents to seek necessary medical attention for the family. Mrs. Andrews would appear to accept the worker, and would make plans for obtaining medical care, but later she would change the plans or put them off. At first she was quite defensive about the abuse charges and tried to convince the caseworker that everything was all right. Both parents were finally induced to attend the parents' meetings.

Immediately after the first meeting, Mrs. Andrews kept her first appointment at the agency's office. During that interview she broke down, saying, "That movie at the meeting was intended for Ira and me." The group leader had shown a film concerned with marital difficulties; it depicted a husband going out and getting drunk because of pressures at home. Mrs. Andrews then brought up her concern about her marital problems and her husband's drinking. Up to this point she had defensively denied any marital or drinking problems. Participation in the meetings had helped her to bring out and discuss her need for help.

This paved the way for a better working relationship with her caseworker, who was then able to help Mrs. Andrews develop more understanding of her husband and of her own feelings. The meetings provided an opportunity to the couple for evenings out and stimulated them to plan other activities together. The marital relationship improved as did the relationship with the children. Mrs. Andrews' comments about the meetings were: "We have so much fun," and "The meetings are relaxing. Afterward I am not so tired and irritable with the children."

We closed this case when the couple demonstrated increased ability to assume their responsibilities as parents.

Still another case, the Martins, suggests a way in which parent meetings can assist the caseworker in one phase of her work with a family. The worker was attempting to help Mr. Martin overcome feelings of insecurity, which had resulted in friendlessness, possessiveness toward his wife, and harsh treatment of their children. The fact that the Martins had no social contacts was a source of conflict between them. Mr. Martin's perception of himself in relation to other people was reflected in statements he made to the group at the early meetings, such as "You don't like what I say" and "Everything I say is wrong." The group assured him that they liked him even if they did not agree with everything he said.

The positive responses he received from the group seemed to encourage Mr. Martin to attempt other interpersonal relationships. He made a conscious effort to be friendlier with his neighbors, whom he had ignored in the past. At first this new friendliness consisted merely of speaking to his neighbors. However, Mr. Martin was able to recognize his own positive feelings about his ability to do this and his enjoyment of the responses he received. He then demonstrated his increased security in his relationships with others by inviting some neighbors to visit his home. Later he expressed a desire to form a discussion group in his neighborhood.

The efforts to help Mr. Martin understand himself better and become more socialized are still in progress. The meetings have helped the caseworker toward this goal by providing this man with a testing ground for experiencing a pleasurable relationship with a group and helping him to move on toward others.

## *Conclusions*

It should be noted that the members of the group described varied in age, economic status, and intellectual capacity, and included both Negroes and whites, as well as both sexes. This suggests that the major ingredient in selection of the participants is the similarity of their problems. This idea is, of course, open for further observation and study.

We have concluded that such meetings, geared to the intellectual capacity, knowledge, experience, and interests of our clients, can give them an enriching experience and can assist us in our efforts to help them become better parents. At present we do not know how lasting some of these effects may be. In order that these new-found satisfactions might be continued and developed further after the meetings are over, we are considering ways in which the families now participating in our second series of meetings may be helped to move into other community group activities.

We are also considering measurement techniques for making objective evaluation of various phases of such projects.

We sincerely think that the parents gained from the experience. The following are a few direct quotations from the parents' own comments about the meetings:

"On the way home from the meetings we stop for hamburgers, like a couple of teen-agers on a date."

"The meetings help me more when I get home and think about them."

"My wife talks about nothing else. Although she doesn't talk much in the meetings, we discuss everything that happened. This is the first thing she has been interested in that we can talk about together."

"It is the only time I have to sit down and think."

"We help each other. One week I get something from the others; the next week they might get something from me."

So regardless of what we think, it is clear that these people are aware of the positive nature of this experience for them. We hope other agencies will form similar groups and report on them so that the use of parent meetings may become an accepted procedure with clients of casework agencies.

# BOOK NOTES

SOCIAL PERSPECTIVES ON BEHAVIOR; a reader in social science for social work and related professions. Edited by Herman D. Stein and Richard A. Cloward. Foreword by Gordon Hamilton. The Free Press, Glencoe, Ill. 1958. 666 pp. $7.50.

This collection of more than 50 papers is planned, according to the editors—both social scientists—to help social workers and others to apply the concepts and findings of social science to their practice. They expect the book to be useful not only to social workers and social-work students, but also to teachers, psychologists, and psychiatrists.

Besides a group of 15 papers on family structures and ethnic patterns, the book includes a number of papers concerned directly with children and youth. Among these are discussions of age and sex in social structure; of social class and racial differences in child rearing; of social-class values and practices in school and settlement-house programs; of social classes in the organization of leisure-time services for youth; and of the conflict of values in delinquency areas.

EMOTIONAL PROBLEMS OF ADOLESCENTS. J. Roswell Gallagher and Herbert I. Harris. Oxford University Press, New York. 1958. 174 pp. $3.50.

Addressed to persons who deal with adolescents either in groups or individually, this book, by a pediatrician and a psychiatrist, emphasizes the importance of understanding the stresses of adolescence and of having a real feeling for the individual. Noting that adolescents differ from both children and adults, the authors define the three chief problems that face all adolescents as: gaining recognition from their peers; matters associated with sex; and acquiring independence.

The adolescent's reaction to these normal confusions and to pressing individual problems, such as poor school progress or dissension at home, are discussed in relation to the need for keeping the young person's emotional turmoil from becoming incapacitating to him. The authors urge that in helping an adolescent to deal wth such problems adults recognize his individuality.

CONCEPTS AND METHODS OF SOCIAL WORK. Walter A. Friedlander, editor. Contributors: Henry S. Maas, Gisele Konopka, and Genevieve W. Carter. Prentice-Hall, Englewood Cliffs, N. J. 1958. 308 pp. $4.50.

The workings of the three primary types of social-work practice—casework, groupwork, and community organization—are described by the contributors to this book, which is addressed to experienced social-work practitioners for use in seminars and inservice training study groups; social-agency board members; citizens who care for the well-being of the community; and persons in other lands who want to learn about social-work concepts and methods in the United States. The editor, who is professor of social welfare at the University of California, has written the introductory chapter, on the generic principles of social work, and the final one, on social-welfare administration and research.

A GUIDE FOR CHILD-CARE WORKERS: for houseparents, counselors, children's supervisors, attendants, and child-care workers in children's institutions and hospitals. Morris Fritz Mayer. Foreword by Joseph H. Reid. Child Welfare League of America, 345 East 46th Street, New York 17, N. Y. 1958. 184 pp. $2.25.

According to the author, this book is presented to child-care workers as a guide rather than as an outline of duties. Beginning with a discussion of the meaning of institutionalization to the individual child and of his interaction with the other children and with the adults in charge, it goes on to consider the child-care worker's role in various facets of institutional life. It notes the importance of children's meals in the institution's social, education, and therapeutic plan; describes daily institution routines; and explains the child-care worker's part in helping children find successful recreational experiences, in maintaining discipline, and in some instances in helping parents help their children.

Finally the book stresses the importance of teamwork between the child-care worker and the rest of the institution's staff. An appendix presents an account of a conference between a child-care worker and her supervisor.

The book is addressed to child-care workers in all types of institutions, whether for dependent children, the emotionally disturbed, delinquents, the mentally retarded, or the mentally ill.

FOOD GUIDE AND QUANTITY COOKING FOR YOUNG CHILDREN. Community Council of Greater New York. Foreword by Benjamin Spock. Harper & Bros., New York. 1958. 189 pp. $4.95.

A committee of nutritionists and home economists has prepared this publication "as a guide for directors and staff in day-care centers, kindergartens, nursery schools, play groups, and other group services for young children where feeding is a part of the daily program." The authors stress the importance of cooperative planning between parents and the staff of the facility to ensure adequate recognition that the food served to the children while under group day care can meet only part of their total nutritive needs.

Introductory chapters deal briefly with the nutritional needs of young children; menu planning and meal service; purchasing, storage, and preparation of food; equipping and staffing food service.

More than half the pages are devoted to recipes in quantities for serving 15, 30, or 45 children. Since many of the recipes are appropriate for children of all ages an introductory table estimates the number of servings for children in three age groups from 6 to 12 inclusive.

FAMILY-CENTERED MATERNITY NURSING. Ernestine Wiedenbach. G. P. Putnam's Sons, New York. 1958. 345 pp. $5.50.

The author of this book, who is associate professor of obstetric nursing at Yale University School of Nursing, addresses it primarily to nurses working in the field of maternal and infant health, but also to "couples who look to nurses for help, reassurance, and guidance when they are faced with the overwhelming experience of parenthood." The book discusses preparation for conception; fertilization and heredity; labor; the newborn; the puerperium; and the postpartum period, including lactation.

FAMILY RELATIONSHIPS AND DELINQUENT BEHAVIOR. F. Ivan Nye. John Wiley & Sons, New York. 1958. 168 pp. $4.95.

This book reports on a study of parent-child relationships in more than 2,000 high-school boys and girls. The young people are classified and rated on the basis of their own written statements concerning their behavior as "most delinquent" and "least delinquent." None was what the author calls "officially delinquent." All were living in small or medium-sized communities.

The boys' and girls' statements about their behavior were made anonymously on a questionnaire that asked whether they had committed any of 23 specified delinquent acts since they entered grade school, and if so how often. The questionnaire also included questions on family matters such as father's occupation, employment or nonemployment of mother outside the home, family quarreling, and attitudes of parents toward child and of child toward parents.

No difference was found in the amount of delinquency among children of lower socioeconomic levels and those of higher levels. This, the author says, does not occur when children in correctional institutions are compared with children living in the community, as children of lower socioeconomic levels are more likely to be committed to such institutions. Children in institutions were not included in the study because, according to the author, the traumatic processes—arrest and so forth—leading to commitment are likely to change the feelings both of the child and the parents, and comparison would suggest spurious differences between delinquents and nondelinquents.

# Guides and Reports

HELPING YOUR CHILD TO UNDERSTAND DEATH. Anna W. M. Wolf. Child Study Association of America, 132 East 74th Street, New York 21, N. Y. 1958. 63 pp. 60 cents.

Suggestions for answers to children's and parents' questions about death. Includes discussion from the points of view of Catholics, Protestants, and Jews, and describes some death ceremonials of primitive peoples.

SOCIAL PROCESS IN THE COMMUNITY AND THE GROUP; significant areas of content in a social work curriculum. Grace Longwell Coyle and Margaret E. Hartford. Council on Social Work Education, 345 East 46th Street, New York 17, N. Y. 1958. 89 pp. $1.

Two papers offering guides to social-work educators interested in the construction and content of courses on social and group process, and illustrating how social-science content may be introduced into the social-work curriculum.

KOREAN-AMERICAN CHILDREN IN AMERICAN ADOPTIVE HOMES. Margaret A. Valk. Child Welfare League of America, 345 East 46th Street, New York 17, N. Y. 1957. 16 pp. 50 cents.

Observations concerning the initial adjustment of Korean-American children adopted in this country through the joint cooperation of International Social Service, a local child-welfare agency, and the Korean Child Placement Service—and in some cases of missionary groups in Korea.

FATIGUE OF HOMEMAKERS WITH YOUNG CHILDREN. Elizabeth Wiegand and Irma H. Gross. Department of Home Management, Michigan State University. Technical Bulletin 265. 1958. Available without charge from Bulletin Office, Box 231, East Lansing, Mich.

Reports degrees of fatigue in mothers with at least two children under school age in relation to such factors as physical conditions in the home and mothers' attitudes toward different tasks.

MEDICAL SOCIAL WORK; preparation and performance. Report of a conference sponsored by the Medical Social Division of the National Foundation for Infantile Paralysis, Arden House, Harriman, N. Y., March 3–7, 1957. 1958. 64 pp. Free from the Foundation, 800 Second Ave., New York, 17, N. Y.

Results of workshops on the professional development of medical social workers and the knowledge, attitudes, and skills needed by them in giving service to children and adults.

PUBLIC WELFARE SERVICES TO CHILDREN IN THEIR OWN HOMES. Annie Lee Sandusky. Child Welfare League of America, 345 East 46th Street, New York 17, N. Y. 1957. 15 pp. 30 cents.

An explanation of how child-welfare services can prevent the separation of families and children; and of the other community services needed to make them fully effective—especially aid to dependent children, homemaker services, and day care.

CHILDREN, TOGETHER; a manual for study groups on integration in public education. American Jewish Congress, 15 East 84th Street, New York, N. Y. 1957. 62 pp. $1.

Presents questions and background information on school segregation of Negroes in the United States for discussion groups in northern communities concerned with "answering their conscience" on the question of equality of educational opportunities in their own neighborhoods.

# HERE AND THERE

## *85th Congress*

Before closing last summer the 85th Congress enacted a number of laws with direct bearing on the health, education, and welfare of children. They included:

### *Social Security Amendments*

New *amendments to the Social Security Act* increase, under a different kind of formula, the Federal contributions to the States for public assistance, including aid to dependent children, and open the way for future increases in Federal grants for crippled children's services, maternal and child-health services, and child-welfare services. The amendments also make changes in the old-age, survivors', and disability insurance program which will increase the amount of benefits to survivors of covered workers, as well as to dependents of retired workers, make benefits available for the first time to dependents of disabled workers, and liberalize the eligibility requirements in regard to adopted children.

The increases in Federal contributions to the States for *public assistance* result from new formulas for reimbursing the States which apply maximums to average expenditures per recipient rather than to individual payments and for the first time are based in part on the per capita income of the States. They went into effect on October 1.

Under the new formula in the *aid-to-dependent-children* program, the maximum average per recipient in which the Federal Government can participate is $30 per recipient. Formerly, individual maximums were set at $32 for the first child and for the person caring for him and $23 for each additional child.

Federal funds available to the States for ADC under the new formula are estimated to be increased by an average of $1.17 per recipient. Forty-three States will receive increases per recipient varying from 6 cents to $4.90, while 5 States will receive no increase and 3 will suffer a slight decrease. How much of the increases are passed on to recipients will be determined by the States.

The amended act raises by $5 million each the total amounts authorized for grants to the States in the three programs under *title V*—maternal and child-health services, crippled children's services, and child-welfare services—making the amounts now authorized for these programs respectively: $21,500,000; $20,000,000; and $17,000,000. Previously the authorizations for these programs were $16,500,000, $15,000,000, and $12,000,000, the amounts appropriated by Congress for the fiscal year ending June 30, 1959.

The amended Social Security Act for the first time allows Federal funds for *child-welfare services* to be used to serve children in urban areas on the same basis as rural children. It also revises the formula for allotting Federal child-welfare funds to States so that the amount granted to a State for any fiscal year (after allotment of the uniform grant) will be in direct proportion to the State's total population and in inverse proporton to its per capita income. However, no State is to receive less than it would have received before the 1958 amendments were enacted. This provision is now effective.

Beginning with the fiscal year 1960 States must meet at least a prescribed share of all child-welfare expenditures. At present States are required to pay part of the cost of child-welfare services in predominantly rural areas, but no State financial participation is required for other services for which Federal child-welfare funds are authorized, such as State services to assist localities in organizing programs.

Other child-welfare-services amendments provide for the reallotment of unused Federal funds, for the use of funds for the return of runaway children under 18 (formerly limited to children under 16) and for the establishment of an Advisory Council on Child Welfare Services, to make recommendation to the Secretary of Health, Education, and Welfare and to Congress before January 1, 1960.

The amended act for the first time extends both the public-assistance and title V programs to Guam.

The changes in the *social insurance program* regarding disabled workers make it possible for benefits to be paid to any children of a disabled person who are under 18, to any over 18 who were disabled before their 18th birthday, and to a disabled person's wife if she has eligible children in her care or if she has reached the age of 62.

### *National Defense Education Act*

Science and modern languages receive the major emphasis in the National Defense Education Act of 1958. (Public Law 85–864, approved September 2, 1958.) The act authorizes grants and loans to the States and to institutions of higher education for:

(1) Loans to students in institutions of higher education, especially those with "superior academic background" who desire to teach in elementary or secondary high schools or who show superior capacity in science, mathematics, engineering, or a modern foreign language.

(2) Financial assistance for strengthening science, mathematics, and foreign-language instruction in public elementary and secondary schools.

(3) Programs in public secondary schools of testing students to identify those with outstanding aptitudes and ability; and of guidance and counseling to advise students in regard to courses and to encourage outstanding students to enter institutions of higher education.

(4) Establishment and operation by institutions of higher education of institutes for modern foreign-language teachers, and of centers for teaching those modern languages not now commonly taught in the United States.

(5) Research and experimentation in the use of various media of communication for educational purposes.

(6) Extension of vocational-education programs.

(7) Establishment or extension of programs to improve educational statistical and reporting systems.

The act also authorizes establishment of a science-information service within the National Science Foundation.

The Congress appropriated $40 million for the fiscal year ending June 30, 1959 of the $182,800,000 the act authorizes for these purposes, for this year.

In another act, the Congress authorizes appropriation of not more than $50,000 this fiscal year and each fiscal year hereafter to foster establishment of clubs composed of boys and girls with a special interest in science and expressed the intention of ultimately chartering these in a corporation similar to the Future Farmers of America. (Public Law 85–875, approved September 2, 1958.) No funds have been appropriated.

### *Other Measures*

The Congress authorized the Surgeon General of the Public Health Service to make grants in aid, up to $1 million, to *schools of public health* for comprehensive professional training, specialized consultive services, and technical assistance in the fields of public health and in administration of State and local public-health programs. In allocating the funds the Surgeon General must give primary consideration to the number of Federally sponsored students attending each school. The grants may be made only in the fiscal years 1958–59 and 1959–60. (Public Law 85–544, approved July 22, 1958.) No appropration has been made.

Under an amendment to the *Food and Drug Law*, the safety of a chemical used in processing food must be proved by industry before the chemical can be sold for use in food. Heretofore it has been necessary for the Government to prove a chemical unsafe after the food item was already on the market.

—Sarah L. Doran

## *Research and Parent Education*

A small conference of research specialists representing the major behavioral sciences met for 2½ days in mid-August at the University of Minnesota to consider the need for reviewing research which might clarify basic thinking about the goals, content, methods, and evaluation of parent-education programs. The conference was sponsored by the Children's Bureau and the University's Institute of Child Development and Welfare. Its agenda focused on research bearing on parent education from three points of view: (1) the development of the parental role; (2) the determinants of parental behavior; and (3) its modifiability.

The group began by assuming that in our complex and rapidly changing society some form of institutionalized guidance for parents will probably be increasingly necessary. There was no agreement as to the forms which this may ultimately take, but there was agreement about the reasons for its importance: (1) there are societal goals to be maintained; (2) parental behavior is known to have a significant influence on the personality development and mental health of the child; (3) appropriate educational experiences can enrich the personalities of parents themselves.

The consensus was that research findings which might help to guarantee the soundness of parent-education programs are woefully inadequate at the present time. This was attributed partly to the tendency in recent years to favor pure over applied research, and partly to the lack of communication between the human-development research laboratories and the organized services to people.

As the discussions went on, it became increasingly apparent that the group would delimit rather than extend the scope of parent education as an educational movement. It was agreed that the most feasible over-all goal for people working with parents is probably to try to help the parent to be a better parent of the kind he already happens to be. Two steps toward this were defined: first, to try to help him to be more clear about what he wants out of life for his children, his family, and himself; second, to make as widely available as possible the simple facts that are known about how children grow and develop.

It was pointed out that these steps would be hard to take because most people working with parents are not trained to deal with the complex problem of future social goals and their implications for citizenship—goals which are now being projected by economists, political scientists, and industrial technologists.

A further complication for parent educators, it was agreed, is the relativity of the parental role: any parent's particular style of parenting is always the result of continuing family interaction. This, it was suggested, may be the reason why parent education which seeks out the mother alone is so apt to be disappointing in its results.

A third difficulty mentioned was the complexity of the role itself. The group defined "role" as a pattern of behavior which is activated by a number of different sets of expectations, some traditional, some legal, some functional, some religious, some the result of cultural changes, some highly personal. In this connection it was pointed out that patterns of parenting develop through the continuous acquisition and discarding of expectations about how both the child and the parent will or should behave—a process which is partly unconscious and in which all the determinants of parental behavior come into play. Agreeing that some of these patterns are modifiable by education and some are not, the conferees underscored the necessity for the professions involved in parent education to come to a better understanding of the differences between therapy and education when each is appropriate and how they may complement each other.

### *Interpretation*

Some warnings were issued in regard to the findings of research: All research in child development is not equally valid; persons advising parents need to know which studies can be taken as read, and which should be considered in relation to others which may modify or contradict them; so many changes of position with respect to certain aspects of child rearing might not be necessary if the research interpreters weighed more carefully some of the ideas they promote.

At several points in the discussion there was a swing away from the "If you feel right, you'll act right" theory. New studies were cited which seem to indicate that what the parent actually does to the child is more important than the underlying attitude. It was the sense of the group that the handling of immediate situations has a cumulative effect which may mean progress toward long-range objectives, if long- and short-range goals are reasonably clear and well related.

The discussion revealed that new work in sociology, anthropology, and social psychology is questioning some of the conclusions about the American class system based on earlier studies. For example, attention was called to studies which show the great number, variety, and flexibility of subgroups. It was predicted that better methods of detecting and delineating these would some day provide a basis for tailoring parent-education programs to their specific needs, interests, aspirations, and problems.

It was further suggested that group education for parents might well be keyed to transition points in the development of the parent role—times at which parents have a special readiness for certain kinds of specific information. The need for research to determine these points was stressed.

### *Summing Up*

A summing up in the final session of the conference indicated a consensus on the following points:

1. Parent education has perhaps lost its identity as a special field of education. Today every professional person who works with children and families teaches parents, whether he realizes it or not.
2. The responsibility for interpreting what is known about child development to parents is shared by many different professional fields.
3. One of the most important jobs ahead in parent guidance is to reach a higher level of interdisciplinary agreement as to goals, content, and methodologies.
4. There is specific and immediate need for the expansion and improvement of training opportunities for three types of parent educators: (1) The professional person—nurse, doctor, social worker, teacher—who works with children and families; (2) the parent-education specialist; (3) lay leaders (highly controversial).
5. For all these types of parent educators, more familiarity with recent developments in communication theory would be highly advantageous.

A detailed report of the conference will be available in the proceedings.

—**Muriel W. Brown**

## *Uprooted People*

Two international conferences, held simultaneously in Vienna last August, focused on the effects of intercountry migration on individual mental health. They were the annual meeting of the World Federation for Mental Health and a special meeting sponsored by the Federation for social scientists and administrators of government immigration programs. The common emphasis, a plea not to categorize immigrants but to see them as individuals, was sharpened by the fact that many of the participants at both meetings were persons whose knowledge of the problems of uprooted people came from personal as well as professional experience. These included psychiatrists, social workers, sociologists, and representatives of related professions.

Concerned with the effects of both voluntary and enforced mobility the conferees saw these as not only involving millions of people throughout the world today but, because of political, social, and economic conditions, as likely to involve many more millions in the future. While asserting that mobility in our times has positive as well as negative aspects, they called on all members of the "helping professions" to work toward the minimization of the forced movement of people and toward the building up of receptive attitudes toward newcomers in receiving countries.

### *Common Experiences*

Without lessening their emphasis on the individuality of needs and reactions of moving people, the participants identified some common experiences of all—change in environment, the phenomenon of being a stranger, and a change in internal identity—resulting in a sense of insecurity. The intensity of the insecurity and its byproducts in attitudes toward self and others, it was pointed out, are largely governed by the person's motivation for leaving his country of origin—that is, whether because of fear, pressure, or ambition. One discussion group summarized immigrant reaction to resettlement as moving from idealization of the new country, through disillusionment with it and nostalgia for the country of origin, to a more realistic view of both. All these reactions, it was asserted, are complicated in many refugees by a sense of guilt in regard to those they have left behind.

The conferees stressed the importance of keeping families and children together in all stages of migration. It pointed out that the presence of its children contributes to a refugee family's sense of reality, maintenance of values, and will to survive. In regard to the effects of flight or forced migration on children themselves it was reported that the young child within the family group, who is protected by "the womb of love," apparently undergoes little emotional strain if resettlement to a new country comes quickly; but if the family remains in a transit camp for a long period of time the child's relationship to his parents, particularly to his father, may be damaged by devaluation of the father role.

Uprooted teen-agers, whether with or without families, it was asserted, may suffer a serious psychological shock, for all the props which normally support the adolescent in his internal struggle with the regressions and aggressions of adolescence are torn asunder. However, it was also pointed out that in resettlement teen-agers and young adults are apt to make a more successful adjustment than older adults; and that difficulties arising from this fact may come in the form of a shift in familial roles—the teen-age child becoming the "knowing" and therefore authoritative person—and of culture conflicts between parent and child.

The protections needed in the intercountry adoption of children were also discussed.

While the conference focused largely on the emotional problems of adjusting to resettlement, the psychological turmoil of the refugee "in limbo" came in for considerable discussion. In this regard it was pointed out that mentally healthy people in a socially unhealthy environment often exhibit psychoneurotic behavior. One year is the longest period of camp life most refugees can take before their will and determination begin to disintegrate, it was said. A figure of 40 million was presented as an estimate of the number of unsettled refugees throughout the world today.

The 1959 meeting of the Federation will be held in Barcelona, Spain.

—**Betty Barton**

## *The Mentally Retarded*

Plans for helping special clinics for mentally retarded children to improve their work were made at a meeting in Washington in mid-September of the technical committee on mental retardation, established to consider next steps in carrying out the recommendations of a conference, sponsored last spring by the Children's Bureau, of directors of clinics and of State maternal and child health programs.

As steps toward improved diagnosis the committee designated a member to work with the American Association on Mental Deficiency in creating a system of standard nomenclature and classification, and asked the Children's Bureau to develop from record forms used by the clinics a list of suggested standard items for uniform reporting.

In an effort to facilitate the exchange of information the committee recommended regional conferences of clinical teams, a review of services for abstracting technical articles, and the establishment of an exchange service within the Children's Bureau for distributing information supplied by the clinics, such as accounts of unusual cases.

Three steps aimed at preventing mental retardation due to phenylketonuria were agreed upon: (1) The Children's Bureau will collect information on ways now used for detecting the disease and treating the child; (2) The committee will ask experts on phenylketonuria to develop a guide for setting up programs to combat the disease; (3) A method of carrying out a nationwide census of cases of the disease will be developed.

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The number of States sponsoring programs for mentally retarded children has grown from 4 to 44 in the last 3 years. Of these 30 are operating projects supported by special grants made through the Children's Bureau and earmarked for the purpose, reaching a total of $1,300,000 for the fiscal year 1958–59. Fourteen other States are using their own funds or regular maternal and child-health grants to finance mental-retardation programs.

The emphasis in the majority of the projects is on the early detection and treatment of preschool children who are mentally retarded. A number of the projects also emphasize physicians' training in diagnosis and treatment.

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A short-stay residential center for mentally retarded children was recently opened in Pomona, N. Y., by the Five Points House, a century-old nonprofit organization located in New York City. The center, called the Pomona Center for Retarded Children, was established after responses to a questionnaire sent to New York State chapters of the Association for the Help of Retarded Children indicated that such a program was needed.

Chartered by the New York State Department of Social Welfare, the center serves as a temporary substitute home during periods of 1 to 6 weeks for retarded children whose families face emergencies such as illness or expectation of another child or are badly in need of a vacation.

Two cottages, one for boys and one for girls, house about 20 children. During the school year the children attend a special school for trainable and educable children. In the summer they participate in supervised outdoor play, including swimming.

Children 5 to 13 years, in good health, ambulatory, and capable of some self-care, are accepted on a fee basis.

## *Against Staphylococci*

Babies discharged from the hospital are the principal means of spreading staphylococcal infections throughout the community, according to the National Conference on Staphylococcal Disease, which met at Atlanta in mid-September under sponsorship of the Public Health Service and the National Research Council. The conference urged special precautions against such infections in nurseries for the newborn, including the elimination of overcrowding and the maintenance of rigid sanitary standards. It also urged that sample surveys be taken of the families of discharged babies to discover nursery-acquired infections.

Other measures recommended by the conference for combating these infections include: organization of infectious-control committees by all hospitals and by local medical societies; classification of all infections and recording of petinent data; development of plans to protect patients from contact with personnel who are known to be carriers of dangerous and epidemic strains; establishment of criteria for use of antibiotics; storage of cultures from staphylococcal infections; and isolation of infectious patients insofar as practical.

Further recommendations call for training hospital staffs in carrying out preventive measures; strengthening laboratory services to identify dangerous strains of staphylococcus; expanding research on environmental factors in the spread of infection; and research on the value of making this kind of infection reportable, on susceptibility to infection, on treatment, and on minimizing development of drug-resistant strains of staphylococcus.

## *White House Conference*

The first publication to be issued in connection with the 1960 White House Conference on Children and Youth came off the press in mid-September in the form of a pamphlet embodying suggestions for studies to be carried out in connection with the conference. These are grouped in four general categories: (1) basic issues underlying much of the present-day concern about children and youth; (2) specific questions interesting persons concerned with child and youth welfare; (3) human-resource inventories; (4) ways in which recommendations of the 1950 White House Conference might be used as a base for further studies.

As "basic issues" the pamphlet posed questions concerning the effects of our current culture and social change on the lives of children. Among the specific phenomena listed as possibilities for inquiry are the effects on children of migration, mothers' employment, early marriages, tensions growing out of attitudes toward minority groups, and the growing pressure for conformity.

As "human-resource inventories" the pamphlet suggests community inquiries into the numbers of physically, emotionally or socially handicapped children, their needs, and the efforts being made to meet them. Its suggestions for following up on specific recommendations of the 1950 White House Conference focus on inquiry into the steps taken thus far toward carrying them out and those remaining to be taken.

The pamphlet is available to study groups upon request to the White House Conference on Children and Youth, 330 Independence Avenue, SW., Washington 25, D. C.

## *For Youth*

As part of a broad program for rehabilitation of boys 16–18 years old who are on the verge of delinquency, New York City's Youth Board recently recommended establishment of a pilot work camp accommodating 50 boys, to be financed jointly by the city and New York State. The board has recommended this type of program for boys who have not been involved in crime, but who are at loose ends because they lack an adequate home and a means of support, or have just been released from treatment for use of narcotics, or for other compelling reasons.

The board suggests that the camp provide a program of work, education, and recreation, with emphasis on guiding and counseling and on moral and religious values. The program would be carried out by qualified persons in the fields of education, medicine, psychology, psychiatry, recreation, and social work.

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The recommendation is one of a series based on a study made by an ad hoc committee, which looked into the foster-care needs of boys between the ages of 16 and 18 under the supervision of the city's courts and public and private social agencies.

"Disadvantaged youth" are to get special attention in a new program adopted recently by the National Child Labor Committee. The program will focus on children of migratory agricultural laborers and of low-income farm families, school dropouts, children not considered educable, and members of minority groups.

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In the school year 1957–58 local agencies assisted more than 300,000 high-school seniors in choosing occupations in line with their potential abilities, educational qualifications, and interests, according to the U. S. Department of Labor. Trained employment-office personnel worked in 8,000 high schools during the school year, offering group guidance, occupational information, individual counseling, and aptitude testing, and making efforts to place individuals in jobs.

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At the second annual meeting of the President's Council on Youth Fitness, held in Washington in September, the Council adopted the following emphases for its program during the ensuing year: finding a systematic means for evaluating fitness; planning an informational kit of aids to communities; developing systematic public relations designed to help youth-serving agencies; acting as a clearinghouse between the Council itself, the President's Citizens Advisory Committee, and local communities; sponsoring workshops to help local projects; bringing together nationwide youth-serving agencies so as to implement, expand, and coordinate programs for youth fitness; and augmenting the quality and quantity of trained leaders for youth activity.

## *Health Research*

Broadening its concept of research in cerebral palsy to include basic and clinical studies of the whole field of brain damage and its consequences, United Cerebral Palsy's Research and Educational Foundation recently established three new training programs: postdoctoral fellowships in brain research; clinical fellowships in cerebral palsy for physicians and dentists; and medical-student fellowships in cerebral palsy.

The postdoctoral-fellowship program in brain research is planned to support research investigators in training who are studying some aspect of the normal and the abnormal brain, and thus to increase the number of investigators qualified to carry on potentially productive studies of neurological disabilities and to improve the quality of clinical training in the specialties involved.

The purpose of the clinical-fellowship plan is to interest young physicians and dentists in the diagnosis, management, and followup of patients with neurological disabilities and to improve the quality of clinical training in the specialties involved.

The medical-student fellowship program is planned to interest medical students in multidiscipline diagnosis, therapy, rehabilitation, and followup of patients with cerebral palsy, or in participating in some phase of basic or applied research relating to brain damage, or both.

Additional information may be obtained from Director of Research, United Cerebral Palsy Research and Educational Foundation, 321 West 44th Street, New York 36, N. Y.

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Some evidence that blood levels of phenylalanine are higher in parents of a phenylketonuric child than in other parents was found in a recent study of 19 such parents and a control group. The blood levels were twice as high in the study group as in the controls, though an overlap occurred between the two groups of about 5 percent. The blood of both groups was tested at intervals for phenylalanine levels after oral ingestion of phenylalanine.

The research was carried out at Harvard University, Children's Medical Center, Boston, and University College, London.

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A study of the effects of high altitudes on pregnancy is being undertaken in the Peruvian Andes by a team of six doctors from various universities in the United States. The team will investigate ways in which animals and human beings adjust biologically to supply oxygen to fetuses.

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Children's Hospital in Washington, D. C., has received a $30,000 grant from the local Junior League to help begin a program for training physicians to care for adolescent boys and girls and for carrying out research in the field of adolescence.

## *Mental Health Year*

More than 100 mental-health and professional societies in 43 countries and territories are joining in plans for a World Mental Health Year in 1960, according to an announcement by the World Federation for Mental Health. The purpose of the conference is to stimulate mental-health activities, including research, with a maximum of international cooperation.

The program's purpose is to increase the study of child development; to gain more knowledge of the causes and distribution of mental illness; to improve and extend the teaching of the principles of mental health in centers of professional training; to develop ways of dealing with human-relations problems in occupational life; and to encourage efforts to find better methods of preventing and treating psychological problems arising from migration within and between countries.

## *Miscellany*

Noting that the shortage of qualified teachers is continuing, the U. S. Commissioner of Education recently announced that an estimated all-time peak of about 45 million persons will enroll in the Nation's schools and colleges during the school year 1958–59—an increase of about 1,750,000 over the enrollment in the previous year.

Public- and private-school enrollment in kindergarten through grade 8 is expected to total about 31,793,000, a gain of more than a million over last year's. High-school enrollments are expected to gain by almost half a million, with a 1958–59 enrollment of 8,880,000. Colleges and universities are expected to enroll about 173,000 more students during the current academic year than they did last year.

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As part of a plan to encourage young people's interest in social work, two North Carolina social-work organizations recently joined in presenting cash awards to two 17-year-old high-school seniors as first and second prizes in a statewide contest open to high-school juniors and seniors. The essays were written on the subject, "Why Social Work Appeals to Me As a Career." Sponsoring the contest were the State Association of Case Workers and the State Association of Superintendents of Social Welfare.

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Abandoned refrigerators—potential death traps for children—are collected and "disarmed" in a project operated by a committee of the Weymouth (Mass.) Junior Chamber of Commerce. Aided by a volunteer truck owner, the committee's workers fulfill requests for pickup service not only in Weymouth but in several neighboring communities.

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Parents of deaf children recently joined to form a parents' section of the Alexander Graham Bell Association for the Deaf. Among the activities that the section expects to carry on are: holding regional parents' institutes and acquainting the public with the problems of deaf children. Additional information will be supplied by the Association, 1537 35th Street, NW., Washington 7, D. C.

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# International Publications

EXPERT COMMITTEE ON POLIOMYELITIS, SECOND REPORT. Technical Report Series No. 145, World Health Organization, Geneva. 1958. 83 pp. For sale by International Documents Service, Columbia University Press, 2960 Broadway, New York 27, N. Y. 60 cents.

In an effort to present a picture of the aspects of poliomyelitis that concern the health administrator, the practical epidemiologist, and the laboratory worker, WHO's Expert Committee on Poliomyelitis, in this second report, reviews national experiences with inactivated poliovirus vaccines in various regions of the world during the past 3 years, discusses the possible usefulness of live-virus vaccines as complementary to the inactivated, and points out the need for recognition of enteric viruses resembling the polioviruses.

Among the committee's recommendations for further research are: Continued search for methods of assessing antigenic potency in inactivated-virus vaccines; study of the stability of immunizing potency in such vaccines, in view of problems of shipment; investigation of all complications following inoculation with inactivated-virus vaccines; continued study of the effectiveness of giving combined agents for immunization from diphtheria, pertussis, tetanus, and polio, and of the optimum schedule for such immunizations; comparative studies of techniques for carrying out virus-neutralization tests; study of techniques for diagnosing paralytic-polio and other enteric-virus infections; further investigation in different parts of the world of the enteric viruses as causes of disease, especially in infants; reinvestigation of basic problems, using the newer, more accurate techniques.

The committee recommends further that the term "nonparalytic poliomyelitis" be eliminated, and "aseptic meningitis" substituted, with an additional phrase indicating the etiologic agent.

REPORT ON A COORDINATED POLICY REGARDING FAMILY LEVELS OF LIVING. Department of Economic and Social Affairs, United Nations, New York, 1957. 71 pp. For sale by International Documents Service, Columbia University Press, 2960 Broadway, New York 27, N. Y. 50 cents.

This report, made by a working group of experts meeting for 3 weeks at Geneva in 1956 under sponsorship of the United Nations and several other international agencies, suggests ways in which nations, especially underdeveloped ones, can help families maintain and improve their standards of living.

The group stresses the desirability of a comprehensive approach to the problem, noting that the policy should comprise two sections: the first to include social insurance, assistance, and related social services; the other, employment, education, health, nutrition, and housing.

The report urges that a coordinated plan be prepared in the light of demographic, economic, social, cultural, administrative, and other factors. It suggests that priorities be given to social measures to prevent family stress and to promote economic development, especially through action directed to large masses of people, and to methods through which individuals and their families join in efforts to raise their living standards.

TEN STEPS FORWARD: World Health 1948–58. World Health Organization, Division of Public Information, Geneva. 1958. 68 pp. 50 cents.

The 10 steps described in this publication took place between 1948 and 1957, the first decade of the World Health Organization's existence. Illustrated by photographs, mainly of children, the chapters describe WHO's work in underdeveloped countries in combating cholera, malaria, kwashiorkor, and tuberculosis; training nurses; and establishing maternal and child-health services; and its work for all countries in publishing an international pharmacopeia, urging steps against radiation hazards, promoting and integrating research on viruses, and studying the use and abuse of drugs in relation to mental conditions.

# IN THE JOURNALS

## Adaptability Needed

Characterizing the life of a social agency as a series of adaptations to change, Charlotte B. Babcock, psychiatrist writing in the *Social Service Review* for September 1958, urges family agencies to meet changing conditions by stressing efforts toward prevention of family breakdown and using greater freedom and imagination in isolating and defining problems before the problems create individual and community panic.

As an example, she cites an expected move into metropolitan areas during the next decade of large numbers of young families unprepared for city life, and suggests as a step toward meeting family emergencies before they become disasters, that workers adapt and modify the classical form of family casework to make it preventive in every sense. The family agency, both in brief contact and continued cases, she says, must "help children and parents integrate disaster and conflict producing phenomena of life events before these become internalized."

Family agencies, the author adds, also have responsibility to relieve "overworked child psychiatrists" by providing direct casework with children, when necessary, as well as to work for improved community services.

## Recreation for the Retarded

A day-camping and a scouting program for severely retarded children is described by the principal of a Los Angeles special public school for such children in the *American Journal of Mental Deficiency* for September 1958. ("Programs for Severely Mentally Retarded Pupils," by Sophia Tichnor Salvin.)

The 2-week day camp is supported financially by various groups—school personnel, a parents' club, a foundation, and public and private community agencies and organizations, and by small fees paid by parents. It is operated by members of the school staff, including a director who serves without pay and three teachers who are paid at a nominal rate, and three college students who have volunteered their services. Scholarships cover the cost of camp attendance for children whose parents cannot pay.

The author reports that the camp experience offers many opportunities for play therapy, that the skills learned by the children at camp are sustained for months, and that the experience affords the staff clues to the children's emotional reactions. She urges that more recreation programs be established for children who are severely mentally retarded.

## Medical Education

On the ground that every doctor, regardless of his type of practice, will have school-age children as patients, the Medical School of the University of California at Los Angeles assigns a family with a child of school age to each second-year student for the next 3 years. The program is described in the *Journal of Medical Education* for September 1958 by Arthur H. Parmelee, Jr., assistant professor of pediatrics, and Lonis Liverman, assistant professor of preventive medicine and public health. ("The Elementary School in Medical Education.")

The assignment is part of a 4-year family-medicine course designed to help students develop a sound doctor-patient relationship through understanding the growth of man in society. During the first year each student studies a family with a baby attending a well-baby clinic.

The second-year assignment includes conferences with the school child's parents, his present teacher, his past teachers, the school nurse, and the school counselor; review of school records; participation in one physical examination of the child. The student also observes the child in the classroom and on the playground and makes visits to the family's home. Once a month the student makes a 2-hour visit to the school with a group of 12 or 13 other medical students, and once a month the second-year students meet together to exchange information on their family assignments.

The orientation of this second-year work, the authors explain, is more toward child development and the educational program than toward the school health program, which is stressed in the 2 later years.

## Against "Hospitalitis"

In an effort to conquer "hospitalitis," the melancholy suffered by many children in hospitals, University Hospital, Ann Arbor, Mich., brings live animals to the children as part of its educational and recreational program. The program is described in *The Modern Hospital* for September 1958. ("Animals Help Them Get Well," by Dr. A. C. Kerlikowske, Mildred Walton, and Richard J. Hinds.)

The hospital maintains a menagerie for the children which at the time of writing contained 2 birds, 6 rabbits, 2 coati mundis, a white mouse, a guinea pig, and a deodorized skunk. In addition visiting animals often are allowed. In learning to care for the pets, the children "realize, almost unconsciously, the value of cleanliness and nutrition in their own lives," the authors maintain, but they add that the primary reason for having the animals in the hospital is to stimulate the children's interest in the pets.

The hospital's school, of which the animal program is a part, begins with nursery school and extends through high school.

## Body Intrusions

Medical procedures involving body intrusions, such as hypodermic injections or the taking of rectal temperatures, seem like hostile acts on the part of doctors and nurses to some young children, according to observations made in a pilot study described by Florence Erickson in the September *Nursing Outlook*. ("Reactions of Children to Hospital Experience.") On the other hand, the author says, the children do not tend to see hostility in oral procedures, such as giving pills or other medicines by mouth or using a tongue blade.

Each of 20 children who were hospitalized or recently discharged and each of 10 who made up a control group was observed—separately—while playing with clinical equipment provided by the investigator, and the child's remarks were recorded. Before beginning an hour's observed play the child was given a hypodermic syringe; a rectal thermomenter; tongue blades; simulated pills; stuffed dolls representing a nurse, a doctor, a boy, a girl; a doll bed and other furniture; and a variety of other toys.

The children expressed clearly their abhorrence of the rectal thermometer, enemas, and injections, and their failure to understand the protective purposes of using such devices, the author notes. Both groups, she reports, showed better understanding of the purposes of orally given medicine.

The experiment was undertaken as a first step toward answering the questions of whether nurses might give better preparation and help to children who must undergo intrusive medical procedures.

### *Adolescent Unmarried Mothers*

The normal problems of adolescence and the practical problems of unmarried motherhood must be considered together in efforts to help teen-age unmarried mothers, says Lola A. Bowman in *Child Welfare* for October 1958. ("The Unmarried Mother Who Is a Minor.") The author is director of casework in the Children's Service Society of Wisconsin. Asserting that most unmarried mothers who reach social agencies have a history of unhappy family relationships, she maintains that the success of the girl's adjustment will depend not only on the degree of her self-understanding and desire for change but also on modifications in her parents' attitudes. Help to the parents may necessarily require more time and skill than help to the girl, she adds.

While pregnant many adolescent girls need foster-family care, according to the author. She points out that maternity homes cannot tailor their programs to the needs of an adolescent who seeks a close personal relationship. She urges continued study of the personal and social causes of unmarried parenthood.

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# Films on Child Life

**Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.**

JOE AND ROXY. 28 minutes; sound; black and white; purchase.

Touches on some problems of teenagers such as going steady, planning for the future, and understanding the purposes of schooling. Contrasts the teen-ager's need for absolute rules against the confusion of adult standards.

*Audience:* Parent-teacher associations and other parent groups; people who work with teen-agers, such as social workers, teachers, religious workers; students preparing for that kind of work; teen-agers.

*Produced by:* National Film Board of Canada, 1957.

*Distributed by:* International Film Bureau, 57 East Jackson Boulevard, Chicago 4, Ill.

WHO IS SYLVIA? 27 minutes; sound; black and white; purchase.

Illustrates problems of a teen-age girl in her relationships with her parents and her friends.

*Audience:* Parents and other adults.

*Produced by:* National Film Board of Canada, 1958.

*Distributed by:* International Film Bureau, 57 East Jackson Boulevard, Chicago 4, Ill.

SOCIAL ACCEPTABILITY. 20 minutes; sound; black and white; purchase.

Suggests the responsibility of parents for helping adolescent children become part of the social group to which they naturally belong.

*Audience:* Parents.

*Produced by:* Crawley Films, 1957.

*Distributed by:* McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 36, N. Y.

HOWARD. 27 minutes; black and white; sound; purchase.

Shows emotional conflicts in an adolescent boy and his parents' perplexity as he struggles to arrive at his first independent decision.

*Audience:* Parent groups; classes studying adolescents and parent-child interaction.

*Produced by:* National Film Board of Canada, 1957.

*Distributed by:* International Film Bureau, 57 East Jackson Boulevard, Chicago 4, Ill.

EXPRESSIVE MOVEMENTS (AFFECTOMOTOR PATTERNS) IN INFANCY. 42 minutes; silent; black and white; purchase.

Shows how expressive movements develop in healthy babies.

*Audience:* College students and professional workers in the areas of child development, psychology, nursing, and pediatrics; parent groups; general public.

*Produced by:* Bela Mittelman, M. D., in collaboration with Laura Malkenson and Ruth L. Munroe, Ph. D.

*Distributed by:* New York University Film Library, 26 Washington Place, New York 3, N. Y.

LITTLE WORLD. 20 minutes; sound; color; purchase or rent.

Depicts the interaction of health services, education, and social work in a day-care center.

*Audience:* Associations of day-care center operators; groups planning for public housing; parent and other lay groups.

*Produced by*: Victor Weingarten 1958.

*Distributed by:* Health and Welfare Materials Center, 10 East 44th Street, New York 17, N. Y.

# READERS' EXCHANGE

**PERKINS:** ***Coordination needed***

Dr. Perkins' article on the health of children of preschool and school age deals with one of the most pressing problems facing all of us in education. We can readily agree that there is a need for better understanding of all of the health factors which play a part in shaping the life of a child. There is also a need for more coordination between the different individuals having direct contact with children. ("Improving the Health of Children of School Age," by Georgia B. Perkins, CHILDREN, September–October 1958.)

The problem would not seem to be one of disagreement as to the need, but rather one of determining a method whereby the contributions of the physician, nurse, dentist, and educator can truly be brought together. Each has an opportunity of access to certain types of information which are not readily available to the other. There is always the problem of propriety in making known information available.

When the various groups who are working with the child have sufficient confidence in each other so that a sharing can take place, the first hurdle will have been overcome. It would seem to be important to recognize that the school alone cannot be, or is not, the means with which all levels of child development can be dealt.

Dr. Perkins points up the need for more parent education prior to enrollment in school. But it is also imperative during the child's school years that the parents' role be more clearly understood by all who are working with the child. An evaluation of the child must be based on what those dealing with him perceive about him, and what their effect on him might be.

Many important observations and data on the great number of children who move from community to community are lost to those who work with them. However successful one community might be in developing a coordination of individuals and agencies within its borders, there is still no consistent pattern for communication between areas. Serious thought needs to be given to how to avoid the loss of vital information as children move from place to place.

The whole problem of communication is, again, one which becomes a stumbling block in the development of an educational program and the acquiring of an education by each individual.

Each community must not only work with its own program, but must relate it to the successful programs in other communities.

*C. Taylor Whittier*
*Superintendent, Board of Education, Montgomery County, Md.*

**RABIN:** ***Another interpretation***

While Dr. Rabin's quantitative data on comparative rates of development in kibbutz and village children seemed interesting, though difficult to interpret, his qualitative findings raised quite serious questions in my mind. ("Kibbutz Children—Research Findings to Date," by Albert I. Rabin, CHILDREN, September-October 1958.)

In general, I did not sense in Dr. Rabin's interpretations the reality of kibbutz life nor a familiarity with the unique flavor of parent-child and peer-group relations in the kibbutz but, rather, a logistic speculation about what *might* be going on.

For instance, Dr. Rabin is quite struck by the fact that kibbutz 10-year-olds express (in questionnaires?) somewhat more positive attitudes to their parents than village children, and he attributes this to the nondisciplinary and permissive role of the kibbutz parent. He misses the important point that the real problem in the relationship between the kibbutz 10-year-old and his parent is not the one of discipline but of affect and attachment. Many 10-year-olds, as they become engrossed in the concerns and activities of the children's society, lose interest in visiting their parents' room. Their parents are pained; the children probably feel guilty. A questionnaire response indicating positive feeling may well be an expiation of guilt or an upgrading of an actually neutral attitude.

Dr. Rabin is also struck by the absence of rivalry between biological siblings—which he (tacitly) assumes to revolve around the problem of sharing possessions. He speculates that for the kibbutz child the experience of having to share is less traumatic because he is used from the beginning to having same-age companions in his room; peer rivalry becomes "worked out in the daily interaction" and "some carryover of the resulting attitudes into the biological family is inevitable."

This interpretation again shows a lack of understanding of what the appearance of a new sibling means to a kibbutz child. Primarily, it means the loss of private time with his mother, for she usually has to go to the infant house to breast feed the new baby in the late afternoon, which is precisely the time until now reserved for the first born. The new baby is mostly invisible, as far as his siblings are concerned, for the infant house is frequently quarantined to protect infants from infectious diseases of the older children. Therefore, the older child's hurt is directed at the mother—he has little opportunity to experience jealousy visibly connected with the new baby. The diary of a kibbutz mother, published in Hebrew, vividly describes the intense resentment of her first-born 3-year-old daughter, a healthy, lively child, at the birth of a new baby. (Shoshana Mushkatbluet, *Yomana Shel Eim*. Sifriat Poalim, Jerusalem, 1949.)

Even later, there are few opportunities for real clash of interests among siblings, who see each other only in the afternoon, in their parents' room. However, an unwillingness to share "personal" possessions with the group is one of the most salient problems among kibbutz adolescents. Many of the "judgments" in children's societies are devoted to a discussion of the problem of envy and unwillingness to share personal possessions, such as watches, fountain pens, and bicycles.

So, while it is quite true that rivalry among biological siblings is rare, this does not mean that the parent-child relation is free from intense hurt and resentment on the older child's part, or that peer groups are free of intense conflict over sharing possessions.

The disturbing factor in Dr. Rabin's speculations is that they perpetuate among the readers a fragmented and unreal image of life in the kibbutz. The kibbutz, as Dr. Rabin says, is "a unique social and economic experiment," and many of us are, as he says he is, "puzzled by the possible effects of kibbutz child rearing on later personality development." But to do justice to a fascinating question, one must avoid quick and easy answers, for they do not answer anything. Before one may understand relationships between isolated aspects of a social system, one must have a "feel" of the daily life of the community, its real-life problems, strains, and pleasures, the personal meaning to the people of objective events.

It takes time and patience to immerse oneself in the life of a community and to postpone measuring until one knows what it is one measures and until one can interpret one's findings. But I for one can see no satisfactory alternative.

*Eva Rosenfeld*
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### *A confirmation*

I was very much interested in Dr. Rabin's report on his research findings on the psychology of kibbutz children. They confirm views which I put forward on clinical grounds at the Seventh Conference on Problems of Infancy and Childhood organized by the Josiah Macy Jr. Foundation in New York in 1953. ("Problems of Infancy and Childhood," Milton J. E. Senn, ed., Josiah Macy Jr. Foundation, New York, 1954. pp. 91–120.) Participants in this meeting received with considerable doubt my clinical findings. These were that whereas below the age of 5 or 6, kibbutz children showed many signs of personal insecurity as compared with Israeli children brought up in traditional families, the two groups were about equivalent by the age of 7 or 8; and in the older age range the kibbutz children seemed psychologically more healthy than the others.

The main reason for the doubts expressed at this meeting was that my findings seemed at first sight to negate our currently held views on the primary importance of early childhood experiences in moulding later personality development.

A lively discussion, reported in the transactions of the conference, eventually led to the realization that although the findings needed validation by such work as that now described by Rabin, they are not at variance with psychoanalytic child psychology, as long as the cultural factors associated with the different trajectory of life experiences of a kibbutz child, as compared with a child raised in a traditional family setting, are taken into account.

The reasons for the signs of early insecurity are discussed by Rabin. At the Macy meeting these were analyzed in more detail, with particular reference to the privations introduced by conflicts of identification in the small child's mind due to his having to relate not only to his parents, but also to his nurses who are responsible for his feeding, toilet training, and general management.

The interesting question is why this insecurity does not persist. Our major explanation was that in the kibbutz the peer group becomes by the age of 6 or 7 the major factor in the psychological life of the child. He is constantly immersed in this group, and the adults of the kibbutz encourage the group to act as the main controlling force in the lives of its members. The special group culture which usually develops is similar to the atmosphere we artificially promote in certain therapeutic groups for the milieu treatment of severely disturbed patients.

It would appear that it is the ego-support and the incorporation of peer-group values which occur increasingly during the later stages of childhood in the kibbutz that reverse the earlier negative trends caused by the privations of partial parent-child separation and the shortcomings of institutional child care.

This interesting idea could be validated by longitudinal studies of the same kibbutz children followed from early to late childhood. Despite the methodological problems mentioned by Rabin, this would clearly be a very worthwhile undertaking. Meanwhile Rabin's results confirm the existence of the paradox.

*Gerald Caplan, M. D., Associate Professor of Mental Health, Harvard School of Public Health, Harvard University.*

### LARSON: *A need for services*

Children receiving OASI benefits have problems other than those directly related to financial need. ("Children Receiving OASI Benefits," by Neota Larson, CHILDREN, September-October 1958.) This point is brought out clearly by Neota Larson as she shows the increasingly explicit emphasis in the OASI program on strengthening the capacity of the family to plan for its own future. This emphasis is revealed through the agency's awareness of the sensitive understanding of human needs required for selecting the representative payee for the child and for adults incapable of managing their own funds, and through the Federal agency's participation in health and welfare planning, a role designed to improve the availability and effectiveness of services.

In this description we have a clear demonstration of the fact that an agency's concern for its clientele makes it difficult to limit a service when problems are so intense and evident that they cry for solution. Theoretically, it might be possible to limit an income-security program to the provision of money. Practically, it is extremely difficult to place such limits. Whether in the future the Social Security Administration will be compelled by the intensity of family need and the slowness of the development of community services to take a more direc [illegible] in the provision of services is an interesting question.

This article should serve as a reminder to community social-welfare leadership of the need to work constructively and professionally with an important Federal agency. The concerns mentioned in this article are not limited to the Bureau of OASI; they reach all segments of community life.

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## SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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JUVENILE COURT STATISTICS, 1956. I. Richard Perlman. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 47. 1958. 16 pp. Single copies available from the Bureau without charge.

In 1956, for the eighth consecutive year, the number of juvenile-delinquency cases reported to the Children's Bureau was higher than the number reported in the previous year, according to this report. The increase over the 1955 figure was 21 percent; the increase in the child population was only 3 percent.

HOMEMAKER AND RELATED SERVICES, 1958: a directory of agencies in the United States. Department of Health, Education, and Welfare: Public Health Service; Social Security Administration: Bureau of Public Assistance and Children's Bureau. Public Health Service Publication No. 598; Bureau of Public Assistance Report No. 34; Children's Bureau Publication No. 370. 1958. 75 pp. Single copies available from any one of the agencies.

For each of 145 agencies providing homemaker and related services in 32 States, the District of Columbia, and Puerto Rico, this publication gives street address, telephone number, names of executives, number of homemakers employed, and number of families that received homemaker service during the week the report was made.

SOCIAL WORKERS LOOK AT ADOPTION; a report of a meeting on the role of the social agency and the social worker, held by the Children's Bureau May 27–29, 1957. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 369. 1958. 19 pp. 15 cents.

The meeting reported in this publication was attended by 16 social workers, from public and private adoption agencies, maternity homes, councils of social work, and hospital social-service departments. The conference agreed that accomplishment of adoption on a sound basis requires the coordinated work of members of the professions of medicine, law, and social work and that this is best accomplished through a social agency. They noted that the social worker brings to adoption special skill in evaluating the social situation and helping the natural and the adoptive parents so that they can make the best possible plans.

THE RESEARCH ATTACK AGAINST CEREBRAL PALSY. Department of Health, Education, and Welfare, Public Health Service, National Institutes of Health, National Institute of Neurological Diseases and Blindness. PHS Publication No. 552. 1958. 20 pp. 20 cents.

This booklet briefly describes types of cerebral palsy, its effects on a child's emotional development, associated handicaps, and factors in causation. It notes the work of the National Institute of Neurological Diseases and Blindness in carrying out research planned to bring about better methods of diagnosis, prevention, and treatment of cerebral palsy and in supporting and coordinating similar research throughout the country.

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